MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 68735

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Baltimore
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) 52 Catonsville
MARYLAND
LENGTH OF STAY (in this place) one Yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Baltimore COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville 52
STREET ADDRESS (If rural give location) 420 Accademy Rd.

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) (Last) Alagna

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 30 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 13 1896

9. AGE last birthday: 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Cement Masson

10b. KIND OF BUSINESS OR INDUSTRY: (Construction)

11. BIRTHPLACE (State or foreign country): Marsala (Italy) 56

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Francesco Alagna

14. MOTHER'S MAIDEN NAME: Angelina Parrinello

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 577-10-7125

17. INFORMANT & ADDRESS: Frances Alagna 420 Accademy Rd.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) acute coronary thrombosis — Interval Between Onset And Death: 1 day

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, 19..., to 1953, 19..., that I last saw the deceased alive on 11-1-53, 19..., and that death occurred at ..., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Harry S. Kimpel — physician — 1203 Edmondson Ave — 10-1-53.

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) | DATE THEREOF: OCT. 5-1953 | NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL | LOCATION (City, town, or county) (State): BALTIMORE MD.

DATE REC'D BY LOCAL REGISTRAR: 10/2/53 | REGISTRAR'S SIGNATURE: W W Hedrick

24. FUNERAL DIRECTOR: Frank Della Vecchia ADDRESS: 322 S. High St

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08736

# CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 416 (Rev. 1951)

**1. PLACE OF DEATH:**
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN) Glenville
LENGTH OF STAY (in this place) Since 7/17/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove Hosp.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE MD COUNTY Prince Georges
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN —
16 X - 2
STREET ADDRESS (If rural, give location) —

**3. NAME OF DECEASED:** (Type or Print) (First) Margaret (Middle) (Last) Anderson

**4. DATE OF DEATH:** (Month) 9 (Day) 11 (Year) 1953

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Widowed | ? | 89 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ? | ? | ? | |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| ? | ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS |
|---|---|---|
| No | — | Records - Spring Grove |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Arteriosclerosis | |
| | DUE TO | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) Hemorrhage | ? |
| | DUE TO | |
| | (c) | |

331X

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| M. | | |

22. I hereby certify that I attended the deceased from 7/17/53, 19....., to 9/11/53, 19....., that I last saw the deceased alive on 9/11/53, 19....., and that death occurred at 6:25 P. m., from the causes and on the date stated above.

SIGNATURE Cecelia Ward M.D. (DEGREE OR TITLE) Spring Grove Hosp. (ADDRESS) DATE SIGNED 9/11/53

| 23. BURIAL, CREMATION REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 9/14/53 | Mt Olivet | Washington | DC |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Sept 13 1953 | ~~Amanda Downey~~ Victor E. Harry - mgr. | F. Buckson | Hyattsville Md |

Spring Grove records incomplete on this case.

RECEIVED
SEP 16 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

08737

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN X Glyndon
LENGTH OF STAY (in this place) 35 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 112 Butler Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland Baltimore COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Glyndon
STREET ADDRESS (If rural give location) 112 Butler Road

3. NAME OF DECEASED: (Type or Print) (First) Wilmer (Middle) Mai (Last) Arnold

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 29, 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 23, 1872

9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Montgomery County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Dr. R.H. Tompson

14. MOTHER'S MAIDEN NAME: Marcella Gore

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: George W. Arnold, Glyndon, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X

Immediate cause (a) Generalized Carcinomatosis — Interval Between Onset And Death: 19 mo.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Carcinoma of Left Breast. — 3 yrs 4 mo.

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pathological Fracture Rt. Femur — 2 mo.

19a. DATE OF OPERATION: None.

19b. MAJOR FINDINGS OF OPERATION None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) None. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) None. m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR? None.

22. I hereby certify that I attended the deceased from 5-23, 1942, to 9-29, 1953., that I last saw the deceased alive on 9-27, 1953, and that death occurred at 7 A.M., from the causes and on the date stated above.

SIGNATURE D. D. Eagles (Degree or title) M.D. ADDRESS Reisterstown, Md DATE SIGNED Oct 1'53.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct. 1/53 NAME OF CEMETERY OR CREMATORY Reisterstown Methodist LOCATION (City, town, or county) (State) Reisterstown, Md.

DATE REC'D BY LOCAL REGISTRAR 9-30-53 REGISTRAR'S SIGNATURE Mary B. Eline

24. FUNERAL DIRECTOR ADDRESS J.F. Eline & Sons, Reisterstown, Md.

VS. A15

RECEIVED
OCT 2 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

68738

# CERTIFICATE OF DEATH

Reg. Dist. No. 41

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A-5

1. PLACE OF DEATH: COUNTY BALTIMORE — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 53 DUNDALK (22) — LENGTH OF STAY (in this place) 10 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7 NORTHSHIP Rd

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY BALTO.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 53 DUNDALK 22
STREET ADDRESS (If rural, give location) 7 NORTHSHIP

3. NAME OF DECEASED (Type or Print): (First) MATILDA (Middle) SOPHIA (Last) ASKEW
4. DATE OF DEATH: (Month) 9-26 (Day) (Year) 1953
5. SEX: FEM.
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 7/7/1893
9. AGE last birthday: 60 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JOHN MILLER
14. MOTHER'S MAIDEN NAME: CATHARINE VON REMMERT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If year, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 215-24-8980
17. INFORMANT AND ADDRESS: WARREN E. ASKEW — 8434 YORKWAY DUNDALK

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 1 year

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Rheumatic Heart Disease — 30 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1947, to 26 Sept., 1953, that I last saw the deceased alive on 22 Sept., 1953, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
B. W. Hallock M.D. 2900 Dunraven Rd. 9/27/53

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL
DATE: 9-30-53
NAME OF CEMETERY OR CREMATORY: BALTIMORE CEM.
LOCATION (City, town, or county) (State): BALTO. Md

DATE REC'D BY LOCAL REG.: Sept 29-1953
REGISTRAR'S SIGNATURE: Mon M. Kelly
24. FUNERAL DIRECTOR: Walter Bunke Bradley
ADDRESS: Dundalk, Md.

RECEIVED
SEP 30 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 08738 Reg. No. 39

VS. 4-56 (7)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**

COUNTY: Baltimore — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Catonsville 21

LENGTH OF STAY (in this place): 13 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Spring Grove State Hosp 16

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE: Maryland COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 00014

STREET ADDRESS (If rural, give location): 2710 Allendale Rd

**3. NAME OF DECEASED:** (Type or Print) (First) Lewis (Middle) Martin (Last) Bacon Jr.

**4. DATE OF DEATH:** (Month) Sept (Day) 27 (Year) 1953

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | May 15, 1881 | 72 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Life Insurance Agent

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis Bacon

14. MOTHER'S MAIDEN NAME: Anna Dosh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-09-5134

17. INFORMANT & ADDRESS: Ruth H Bacon, 2710 Allendale Rd, Balto

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

539.1

Immediate cause — (a) Bilateral Hemothorax with Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Esophagomalacia with perforation

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Congestion + Edema

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 15, 1953, to Sept 27, 1953, that I last saw the deceased alive on Sept 26, 1953, and that death occurred at 1:15A m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Arthur M Hanson M.D Spring Grove State Hosp. 9/27/53

| 23. BURIAL, CREMATION, REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/30/53 | Methodist Church Cem. | Monkton, Md. |

DATE REC'D BY LOCAL REG. 9-28 REC'D 1953

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS

Wm. J. Tickner & Sons Balto. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6n740

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Baltimore | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Overlea
LENGTH OF STAY (in this place) 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 406 Dale Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Overlea
STREET ADDRESS (If rural give location) 406 Dale Avenue

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) G. (Last) Barthman
4. DATE OF DEATH: (Month) September (Day) 12, (Year) 1953

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widower | Jan. 1, 1883 | 70 yrs. | | | | |

| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bus Driver | Retired 5 yrs. | Maryland | U S A |

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: |
|---|---|---|---|
| Yes | Spanish-Amer. | 212-01-3801 | Roland T. Harris 406 Dale Ave. Overlea |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | Interval Between Onset And Death |
|---|---|---|
| 420.0 Immediate cause | (a) Coronary occlusion | 5 hours |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) Arteriosclerotic heart disease DUE TO | 15 yr. |
| | (c) DUE TO | |

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 10, 1953, to Sept. 12, 1953, that I last saw the deceased alive on Sept. 12, 1953, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

SIGNATURE Adam Gluris (Degree or title) M.D. ADDRESS 6032 Belair Rd., Balto 6, Md. DATE SIGNED Sept. 14, 1953

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | Sept. 15, 1953 | Green Mount | Baltimore, Maryland |

DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS
Burgee Funeral Home 3631 Falls Road
Horace F. Burgee

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

08741

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY BALTIMORE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HALETHORPE
LENGTH OF STAY (in this place) 1 YEAR
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1721 ARBUTUS AVE

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE DELAWARE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WILMINGTON
STREET ADDRESS (If rural, give location) 608 BURMINGHAM AVE.

3. NAME OF [redacted] (Type or Print) (First) JOSEPH (Middle) (Last) BECKER

4. DATE OF DEATH (Month) SEPT (Day) 18 (Year) 1953

5. SEX MALE

6. COLOR OR RACE WHITE

7. ~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify) WIDOWED

8. DATE OF BIRTH Oct. 27, 1872

9. AGE last birthday 80 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY SELF

11. BIRTHPLACE (State or foreign country) KENNETT SQUARE, PENNA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S [redacted] MELCHOIR BECKER

14. MOTHER'S MAIDEN NAME MARY KORMANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 181-01-4223A

17. INFORMANT AND ADDRESS MRS. HARRIET B. ANDERSON 1721 ARBUTUS AVE HALETHORPE, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

17 X

Immediate cause (a) Carcinoma of prostate — Interval between onset and death: 2 yrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Metastases to bone — 4 yr

(c) Toxaemia

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION [illegible] 1950

19b. MAJOR FINDINGS OF OPERATION Hypertrophy prostate —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19 50, to Sept 18, 19 53, that I last saw the deceased alive on Sept 17, 19 53, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Frederick J. Becker (Degree or title) MD ADDRESS 10 W Dreamland Blvd Balto 27-Md DATE SIGNED Sept 18 53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal

DATE THEREOF 9/23/53

NAME OF CEMETERY OR CREMATORY Union Hill Cem.

LOCATION (City, town, or county) (State) Kennett Square, Pa.

DATE REC'D BY LOCAL REG. September 19-1953

REGISTRAR'S SIGNATURE R. W.

24. FUNERAL DIRECTOR Wm. J. Vickers & Sons ADDRESS Balto 17, Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

7

VS. A-

**1. PLACE OF DEATH:**

COUNTY: Baltimore — MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): Owings Mills, Md.

LENGTH OF STAY (in this place): 5 months

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rosewood State Training School

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE: Maryland — COUNTY: Balto.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore (30)

STREET ADDRESS (If rural give location): 1621 Patapsco Street

| 3. NAME OF DECEASED: (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH: | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | Linda | Charlmaine | Berger | | Sept. | 21 | 19 53 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE Last birthday: | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | 3-19-48 | 5 yrs. | | | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Maryland | |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Charles Wm. Berger | Edna Mae Jett |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | | Hospital Records |

**18. MEDICAL CERTIFICATION**

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | Interval Between Onset And Death |
|---|---|---|
| 351X Immediate cause | (a) Status Epilepticus | 1 day |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) DUE TO Inspiratory Pneumonia | ½ day |
| | (c) DUE TO Internal hydrocephalus, secondary to cerebral trauma, face delivery | since birth |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from April 10, 1953, to Sept. 21, 1953, that I last saw the deceased alive on Sept. 21 1953, and that death occurred at 11:15 P.M., from the causes and on the date stated above.

SIGNATURE: I. H. Bruffin Jr. M.D. (Degree or title) — ADDRESS: Owings Mills, Md. — DATE SIGNED: 22 Sept 53

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Sept. 25/53 | Holy Cross Cemetery | Ritchie Highway | Md |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-24-53 | A. W. Hedrich | Krause Funeral Home | 1216 D. Charles St |

Over.

Item 12, Film G158 10/7/53 fcy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Balto — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 54 Essex | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 54 Essex Md.
STREET ADDRESS (If rural give location) 860 Back River Neck Rd.

3. NAME OF (Type or Print) (First) John (Middle) (Last) Berta
4. DATE OF DEATH (Month) Sept (Day) 28 (Year) 1953
5. SEX male | 6. COLOR OR RACE W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single | 8. DATE OF BIRTH 10/10/1883 | 9. AGE last birthday 69 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Hungary | 12. CITIZEN OF WHAT COUNTRY? Hungary.
13. FATHER'S NAME ? | 14. MOTHER'S MAIDEN NAME ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. | 17. INFORMANT Louis Somogyi

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

430.1
Immediate cause (a) Cerebral Apoplexy — 2 wks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-Sclerotic-Cardio-Vascular disease — 1 yr
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1953, to Sept 28, 1953, that I last saw the deceased alive on Sept 28, 1953, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
M Baumgardner MD Balto Md 9/28/53

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 9/30/53 | NAME OF CEMETERY OR CREMATORY Oak Lawn | LOCATION (City, town, or county) Balto Md. (State)

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR C.L. Bruzgulski ADDRESS 1407 Eastern ave Rd.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. ...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

1. PLACE OF DEATH:
COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
MARYLAND LENGTH OF STAY (in this place) lyrlmolldа.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Havre de Grace
STREET ADDRESS (If rural give location) 323 Wilson Street

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) (Last) BLUM

4. DATE OF DEATH: (Month) September (Day) 23 (Year) 19 53

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Separated

8. DATE OF BIRTH: unknown

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Whsl. Fruit dealer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Roumania

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital Records Spring Grove State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

3317

Immediate cause (a) Cerebral Hemorrhage

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Generalized arteriosclerosis

DUE TO

(c)

Interval Between Onset And Death

11 OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-12 ,1952 , to 9-23- , 1953 , that I last saw the deceased alive on 9-23-53, 19 , and that death occurred at 9:45p.m. , from the causes and on the date stated above.

SIGNATURE (Degree or title) Samuel Gross Hospital Catonsville Md ADDRESS J.K. Cowan, M.D. DATE SIGNED 9/13/53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE THEREOF 9/24/53. NAME OF CEMETERY OR CREMATORY New York N.Y. LOCATION (City, town, or county) (State) New York N.Y.

DATE REC'D BY LOCAL REGISTRAR 9/24/53 REGISTRAR'S SIGNATURE A.R. Hedrick M.D.

24. FUNERAL DIRECTOR Sol Funeral Serv. ADDRESS 1124 E. North Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Balto — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: | LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 8428 Pulaski Hgwy

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md — COUNTY: Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X
STREET ADDRESS (If rural give location): 8428 Pulaski Hgwy

3. NAME OF DECEASED (Type or Print): (First) Fred (Middle) J. (Last) Bahlen

4. DATE OF DEATH: (Month) Sept (Day) 21 (Year) 19 53

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married | 8. DATE OF BIRTH: July 18-1883 | 9. AGE last birthday: 70 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Farmer | 10b. KIND OF BUSINESS OR INDUSTRY: Own. Farm | 11. BIRTHPLACE (State or foreign country): Balto Co. Md | 12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: John Bahlen | 14. MOTHER'S MAIDEN NAME: Elizabeth Mohr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT: Mrs Fred J. Bahlen 8428 Pulaski Hgwy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — Few months

420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension & Arteriosclerotic Heart Dis. — 5 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: No | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 28, 19 53, to Sept 11, 19 53, that I last saw the deceased alive on Sept 11, 19 53, and that death occurred at Sept. 21, 1953 3 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Irving R Beck MD | 901 Fuselage Av Baltimore 30 MD | Sept 22/1953

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 9/23/53 | NAME OF CEMETERY OR CREMATORY: Zion Luth Cem | LOCATION (City, town, or county) (State): Balto. md

DATE REC'D BY LOCAL REG.: 9/24/53 | REGISTRAR'S SIGNATURE: Edith Hurley | 24. FUNERAL DIRECTOR | ADDRESS: Lassahn Funeral Home 7401 Belair Rd

VS. A15

RECEIVED
SEP 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY BALTIMORE — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DUNDALK 22 — LENGTH OF STAY (in this place) 4 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7612 SPRUCE Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY BALTO.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DUNDALK 22, NORTHSHIRE
STREET ADDRESS (If rural, give location) 7612 - SPRUCE Rd.

3. NAME OF DECEASED (Type or Print): (First) ETTA (Middle) COMEGYS (Last) BOYCE

4. DATE OF DEATH: (Month) 9 (Day) 28 (Year) 19 53

5. SEX: FEM.

6. COLOR OR RACE: WH.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 19 OCT. 1885

9. AGE last birthday: 67 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN W. COMEGYS

14. MOTHER'S MAIDEN NAME: ELIZABETH REED

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. MILTON A. RINNE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

9744
Immediate cause (a) Strangulation by Hanging

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

INTERVAL BETWEEN ONSET AND DEATH: —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office building, etc.) OF INJURY Home — (CITY OR TOWN) Dundalk — (COUNTY) Balto — (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 9-28-53 — m. — INJURY OCCURRED While at work ☐ Not while at work ☒ — HOW DID INJURY occur? Jump off from Porch

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: W. Davis MD — (Degree or title) — ADDRESS: Dep. Med. Exam. Dundalk 22 Md. — DATE SIGNED: 9/28/53

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE THEREOF: 10/1/53 — NAME OF CEMETERY OR CREMATORY: CHESTERFIELD — LOCATION (City, town, or county): CENTERVILLE, Md. — (State)

DATE REC'D BY LOCAL REG.: Sept 29-1953 — REGISTRAR'S SIGNATURE: Wm. J. Kelly — 24. FUNERAL DIRECTOR — ADDRESS

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 58

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS-A15 8

**1. PLACE OF DEATH:**

COUNTY Baltimore — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville — LENGTH OF STAY (in this place) 13 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE Maryland COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cockeysville

STREET ADDRESS (If rural, give location) Pretty Boy Dam

| 3. NAME OF DECEASED: (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) (Day) (Year) |
|---|---|---|---|
| (Type or Print) Matilda | | Boyd | September 16, 19 53 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed? | Unknown | 70 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Canning Factory | Unknown | U. S. A. |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | Unknown | Records Spring Grove State Hospital |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| 290.0 Immediate cause | (a) Pernicious anemia due to unknown cause | Unknown |
| DUE TO | | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) | |
| DUE TO | | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Ht. Dis. & generalized arterio. Years

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) M. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 9-3-53, to 9-11-53, that I last saw the deceased alive on 9-11-53, and that death occurred at 12:10 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Ethel B. Herrmann Jones M.D. Spring Grove State Hospital Catonsville 28, Maryland 9-16-53

| 23. BURIAL, CREMATION REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 9/17/1953. | New Freedom | New Freedom, York Co., Pa. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9/17/53 | V. E. Harry | Jacob Harlenstein | New Freedom, Pa. |

RECEIVED
SEP 21 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Balto. STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Balto
LENGTH OF STAY (in this place) 19
HOSPITAL OR INSTITUTION OR STREET ADDRESS Lodge Forest 7823 N. Cove Rd

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) Same

3. NAME OF DECEASED (Type or Print): (First) Sylvester (Middle) (Last) Boyer

4. DATE OF DEATH: (Month) Sept (Day) 19 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widr

8. DATE OF BIRTH: Aug 6 1877

9. AGE last birthday: 76 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Watchman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENNA

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 217-05-9748

17. INFORMANT AND ADDRESS: Margaret B. Boyer, Catonsville

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardiovascular disease

(c)

420.1

INTERVAL BETWEEN ONSET AND DEATH: (a) Hours (b) Unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 9 19 53 11PM

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or Title) J. McLearnon M.D. ADDRESS Balto. Co. Medical Examiner Towson Md

DATE SIGNED 9/19/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 9-21-53

NAME OF CEMETERY OR CREMATORY Mt. Carmel

LOCATION (City, town or county) Balto. Md (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 21-53

REGISTRAR'S SIGNATURE Dawson L. Harbey

24. FUNERAL DIRECTOR Wm. Burke

ADDRESS Brooklyn Glendale Md

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

# CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH: Baltimore County
(a) Baltimore ~~City~~, Maryland
(b) Street address 1707 Summit Ave
(c) Hospital or institution: Halethorpe, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City of Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 140 S. Willard Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Anthony Joseph Brender

3 (b) If veteran, name war No | 3 (c) Social Security Account No. 245-12-7152

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife HELEN WHITMORE
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) April 17, 1903

8. AGE: Years 50 | Months 4 | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation Presser

11. Industry or business Mens Clothing

FATHER 12. Name Charles Brender

13. Birthplace Baltimore City

MOTHER 14. Maiden Name Anna M. Knaefer

15. Birthplace Baltimore City

16 (a) Informant Mrs. Margaret Brender
(b) Address 344 Stafford Rd (28)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5/53 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto., Md.

18 (a) Funeral director Harry H. Nuttle
(b) Address 4101 E. Monument Ave

19 (a) 9-3-53 (Date rec'd by registrar) (b) A. W. Pedrick Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1953 at 9:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1953, to Sept 1 1953, and that I last saw him alive on Sept 1 1953

| Immediate cause of death | Duration |
|---|---|
| Adenocarcinoma Stomach with generalized | 3 mos. |
| Due to Metastases | |
| Due to | |
| Other Conditions 151X (Include pregnancy within 3 months of death) | |

Major findings: Of operations Adenocarcinoma stomach with metastases
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. L. F. Meek, M.D. M. D.
Address 11 E. Chase St Date signed 9/1/53

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (5)

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Balto. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Towson Convalescent Home / 301 W. Chesapeake Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY [illegible]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (12)
STREET ADDRESS X (If rural give location)
301 Dumbarton Rd.

3. NAME OF DECEASED: (Type or Print) (First) LINA (Middle) R. (Last) BRICE

4. DATE OF DEATH: (Month) Sept. (Day) 24 (Year) 19 53

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Nov. 24, 1879

9. AGE last birthday: 73 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Edward Brice

14. MOTHER'S MAIDEN NAME: -- Maria Marsh.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 213 - 32 - 1375

17. INFORMANT & ADDRESS: Mr. Edward R. Brice-301 Dumbarton Rd. #12

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

Immediate cause (a) .... Pulmonary Thrombosis (Embolism) DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) .... Arterio sclerosis DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 12, 1953, to Sept 24, 1953, that I last saw the deceased alive on Sept 24, 1953, and that death occurred at 7 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Laurence C. Toth M.D. ADDRESS 6805 York Rd. DATE SIGNED 9/24/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 9/26/53

NAME OF CEMETERY OR CREMATORY Loudon Park Cem.

LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REGISTRAR 9-25-53

REGISTRAR'S SIGNATURE A.W. Hedrich dmr.

24. FUNERAL DIRECTOR Wm. J. Pickner & Sons ADDRESS Balto. 17, Md.

VS. A1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

COUNTY Balto. MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Dusting Ave

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE Md. COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Balto.

STREET ADDRESS (If rural, give location) 330 Whitridge Ave.

**3. NAME OF DECEASED:** (Type or Print) (First) Ernest (Middle) M. (Last) Briscoe

**4. DATE OF DEATH:** (Month) Sept. (Day) 6th (Year) 1953

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 9/11/1887 | 65 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Refinery Inductor | Penna. R.R. | Cecil Co. Md. | |

**13. FATHER'S NAME:** Henry T. Briscoe

**14. MOTHER'S MAIDEN NAME:** Ida Krauss

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | | Alice M. Briscoe 330 Whitridge Ave. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronal Thrombosis | 2 da. |
| DUE TO | | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) Chr. Hypertension Cardio Vascular Disease | 5 yr. |
| DUE TO | | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| M. | | |

22. I hereby certify that I attended the deceased from 9-4, 1953, to 9-6, 1953, that I last saw the deceased alive on 9-5, 1953, and that death occurred at 6:30 a. m., from the causes and on the date stated above.

| SIGNATURE | (DEGREE OR TITLE) ADDRESS | DATE SIGNED |
|---|---|---|
| Nelson K. Gallagher | M.D. Catonsville 28, Md. | 9-8-53 |

| 23. BURIAL, CREMATION REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/9/53 | New Cathedral | Balto. Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-9-1953 | A.W. Hedrich dmr. | H. Cook Inc. | 1217 St. Paul St. |

VS-415 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

**1. PLACE OF DEATH:**
COUNTY Balto. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville 52
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 130 Cherrydell Rd.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md. COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville 52
STREET ADDRESS (If rural, give location) 130 Cherrydell Rd.

**3. NAME OF DECEASED:** (Type or Print) (First) Harriett (Middle) Rose (Last) Brohawn

**4. DATE OF DEATH:** (Month) 9 (Day) 24. (Year) 19 53

**5. SEX:** F

**6. COLOR OR RACE:** W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED,** (Specify) Married

**8. DATE OF BIRTH:** Aug. 28, 1905

**9. AGE** last birthday: 48 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Ret, Clerk

**10b. KIND OF BUSINESS OR INDUSTRY:** Fire Underwriter

**11. BIRTHPLACE** (State or foreign country): Md.

**12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME:** Guy C. Bopst

**14. MOTHER'S MAIDEN NAME:** Harriett Rusk

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:** None

**17. INFORMANT & ADDRESS:** Charles E. Brohawn 130 Cherrydell Rd.

**18. MEDICAL CERTIFICATION**

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:**

171X

Immediate cause (a) Bronchopneumonia — Interval Between Onset and Death: 2 Days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Adeno-Carcinoma — 1 year

DUE TO

(c) Body uterus - and cervix

**II. OTHER SIGNIFICANT CONDITIONS:** Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** June 18 - 1953

**19b. MAJOR FINDINGS OF OPERATION:** Recurrent Carcinoma tonsil

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

**22.** I hereby certify that I attended the deceased from Aug. 46, to Sept 24, 53, that I last saw the deceased alive on 24, 53, and that death occurred at 10 3 m., from the causes and on the date stated above.

SIGNATURE Wm. Barbour Ford (DEGREE OR TITLE) ADDRESS 1118 St Paul St. Baltimore, Md. DATE SIGNED 9/25/53

**23. BURIAL, CREMATION REMOVAL** (Specify): Burial — DATE THEREOF 9-26-53 — NAME OF CEMETERY OR CREMATORY Loudon Park Cem. — LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. 9/27/53 — REGISTRAR'S SIGNATURE V. E. Harry

**24. FUNERAL DIRECTOR** George D. Farley — ADDRESS Catonsville, Md.

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 53

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
LENGTH OF STAY (in this place) 4½ years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dundalk 5
STREET ADDRESS (If rural give location) 13 Broadship Rd

3. NAME OF DECEASED: (Type or Print) (First) Rhue (Middle) M. (Last) Brown

4. DATE OF DEATH: (Month) Sept (Day) 22 (Year) 1953

5. SEX: ♂

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 1/31/1888

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Penn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Washington Logan

14. MOTHER'S MAIDEN NAME: Martha Mc Daniel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Mr George F Brown, 13 Broadship Rd, Dundalk Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause (a) Cerebro vascular accident — Interval Between Onset And Death: 6 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis — ?
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 16, 1953, to Sept 22, 1953, that I last saw the deceased alive on Sept 22, 1953, and that death occurred at 5:55 Pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Arthur M Hanson M.D Spring Grove State Hosp 9/22/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 9-25-53 | NAME OF CEMETERY OR CREMATORY Fairview Cemetery | LOCATION (City, town, or county) (State) Coatesville, Chester Co. Pa.

DATE REC'D BY LOCAL REGISTRAR 9/24/53 | REGISTRAR'S SIGNATURE T E Harry

24. FUNERAL DIRECTOR MacNabb & Sons ADDRESS

VS. A15

RECEIVED
SEP 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]54

# CERTIFICATE OF DEATH

Reg. Dist. No. 4-2

1. PLACE OF DEATH:
COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort Howard
LENGTH OF STAY (in this place) 27 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 2121½ McCulloh Street

3. NAME OF DECEASED: (Type or Print) (First) CHESTER (Middle) A. (Last) BUNDAY

4. DATE OF DEATH: (Month) September (Day) 13 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 6/27/87

9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Porter

10b. KIND OF BUSINESS OR INDUSTRY: Fidelity Trust Co.

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bunday

14. MOTHER'S MAIDEN NAME: Phillis (MN: JACKSON)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WWI

16. SOCIAL SECURITY NO.: 219-22-8589

17. INFORMANT & ADDRESS: Clin.Rec., Vet.Adm.Hosp., Ft.Howard, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X

Immediate cause (a) CARCINOMA OF LUNG WITH METASTASES — Interval Between Onset And Death: Unknown

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 17, 1953, to Sept. 13, 19 53, ~~that I last saw the deceased~~ and that death occurred at 5:45 A.M., from the causes and on the date stated above.

SIGNATURE AUSTIN T. NORTON M.D. (Degree or title)

ADDRESS VAH, Fort Howard, Maryland

DATE SIGNED 9/13/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 9/16/53

NAME OF CEMETERY OR CREMATORY? Baltimore National

LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR 9/15/53

REGISTRAR'S SIGNATURE W W Bennett

24. FUNERAL DIRECTOR ADDRESS: Arlington S. Phillips Funeral Home 1808 N. Monroe Street, Baltimore 17, Md.

J1

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Item 18 Film G158 10-5-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore — LENGTH OF STAY (In this place) 17
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9618 Mason Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Baltr.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore — 14
STREET ADDRESS (If rural, give location) 9618 Mason Ave

3. NAME OF DECEASED (Type or Print): (First) William (Middle) S. (Last) Burke

4. DATE OF DEATH: (Month) Sept (Day) 11th (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: May 14, 1916

9. AGE last birthday: 37 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk, Industrial Bearing Corp

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter F. Burke

14. MOTHER'S MAIDEN NAME: Mary Alice Mullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Geraldine Burke, 9618 Mason Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

411 X Immediate cause (a) Aortic stenosis — Interval between onset and death: 2 years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Rheumatic fever, Inactive. Probably childhood. — ? Unk.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Victor A. McKusick M.D. (Degree & title) ADDRESS Johns Hopkins Hosp. DATE SIGNED 9/12/53

R.C. Hudson M.D., D.M.E.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Sept 15, 1953 — NAME OF CEMETERY OR CREMATORY New Cathedral — LOCATION (City, town, or county) (State) Baltimore Maryland

DATE REC'D BY LOCAL REG. — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Leonard J. Ruck — ADDRESS 5305 Harford Road

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]56

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Pikesville
LENGTH OF STAY (in this place) Lifelong
HOSPITAL OR INSTITUTION OR STREET ADDRESS Augsburg Home

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pikesville
STREET ADDRESS (If rural give location) 6211 Campfield Rd

| 3. NAME OF DECEASED: (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Harry | Dahm | Caskey | Sept. | 3 | 19 53 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | July 18, 1872 | 81 yrs. | | | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | None | Baltimore Md. | |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Joseph | Eliz. Doyle |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | None | Records Augsburg Home 6211 Campfield |

**18. MEDICAL CERTIFICATION**

| | | Interval Between Onset And Death |
|---|---|---|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| 420.0 Immediate cause | (a) Cerebral Hemorrhage | 5 days. |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | DUE TO (b) Arterio - Sclerotic Heart Disease | 6 years. |
| | DUE TO (c) Broncho. Pneumonia | 2 days. |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | - - | |

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from May ..., 1946, to Sept. 3, 1953, that I last saw the deceased alive on Sept. 3., 1953, and that death occurred at ....., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Earl L. Chambers | M.D. | 4108 Liberty Hts Ave. Balto. | 9-4-53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/7/53 | Loudon Pk. Cem. | Baltimore Md. |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Sept 5 1953 | R.W. | Paul A. Harman | 1067 Harford Rd. |

VS-A16

Dr. Chambers
416 Liberty Pats.

1953
1872
81

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 37

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cockeysville
LENGTH OF STAY (In this place) 1½ yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS York Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cockeysville
STREET ADDRESS (If rural, give location) York Road

3. NAME OF DECEASED (Type or Print): (First) Louis (Middle) Franklin (Last) Cofiell

4. DATE OF DEATH: (Month) Sept (Day) 25 (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. (SINGLE), MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: April 6, 1910

9. AGE last birthday: 43 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinist

10b. KIND OF BUSINESS OR INDUSTRY: tool mfg.

11. BIRTHPLACE (State or foreign country): Balto Co. Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Wm. F. Cofiell

14. MOTHER'S MAIDEN NAME: Lottie Benson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-03-3310

17. INFORMANT: Anna C. Cofiell, Cockeysville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Heart disease, vascular, coronary occlusion — Interval between onset and death: sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑ Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Collin C. Hudson (Degree or title) M.D., D.M.E. ADDRESS Towson Md DATE SIGNED 9/25/53

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF 9-28-53 — NAME OF CEMETERY OR CREMATORY Bosley's Methodist — LOCATION (City, town, or county) Sparks, Md. (State)

DATE REC'D BY LOCAL REG. 28 Sept 53 — REGISTRAR'S SIGNATURE Anne Amistead McRae

24. FUNERAL DIRECTOR J. Leo Brooks, Sparks, Md. ADDRESS

RECEIVED
19[illegible]3
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08753

# CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X Sparrows Point
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sparrows Point
STREET ADDRESS (If rural, give location) 702- J. Street

3. NAME OF DECEASED: (Type or Print) (First) Robert (Middle) Riley (Last) Cox
4. DATE OF DEATH: (Month) Sept (Day) 24- (Year) 1953

5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.
8. DATE OF BIRTH: Oct 11-1868
9. AGE last birthday: 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Police Lt.
10b. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel
11. BIRTHPLACE (State or foreign country): Fairmount Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ned Cox
14. MOTHER'S MAIDEN NAME: Sallie Leach

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Louis T Cox. - 1 Eastship Rd. Dundalk. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
420.0
Immediate cause (a) Cerebral Thrombosis — Interval Between Onset and Death: 5 days
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Arterio-Sclerotic heart disease — 5 years
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/24/53, to 9/24/53, that I last saw the deceased alive on 9/24/53, and that death occurred at 2 P.M., from the causes and on the date stated above.
SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Dawson L. Harbor M.D. 914 Dalrut, Sparrows Point 9/24/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF Sept 26-53
NAME OF CEMETERY OR CREMATORY Oak Lawn
LOCATION (City, town, or county) Baltimore Co. (State) Md.

DATE REC'D BY LOCAL REG. SEP 25 REC'D
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Wm Cook Inc Baltimore ADDRESS

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05759

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 15

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodlawn
LENGTH OF STAY (In this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6825 Windsor Mill Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodlawn X
STREET ADDRESS (If rural, give location) 6825 Windsor Mill Road

3. NAME OF DECEASED (Type or Print): (First) Andrew (Middle) C. (Last) Dash
4. DATE OF DEATH: (Month) September (Day) 8 (Year) 1953

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: April 19, 1870
9. AGE last birthday: 83 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Policeman
10b. KIND OF BUSINESS OR INDUSTRY: Balto City
11. BIRTHPLACE (State or foreign country): Lonoconing, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Dash
14. MOTHER'S MAIDEN NAME: Henrietta Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Janet M. Dash, 6825 Windsor Mill Rd Woodlawn, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval between onset and death: 15 Min.

420.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible] that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at 6.30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or Title) ADDRESS DATE SIGNED
[signature] 4509 Liberty Heights Ave.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Sept. 11, 1953
NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG.: 9-9-53
REGISTRAR'S SIGNATURE: A. W. Hedrich
24. FUNERAL DIRECTOR: Willis Lamoreux
ADDRESS: 4510 Liberty Heights Ave.

Item 18 Film G158 9-18-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

0576

Reg. Dist. No. 37

1. PLACE OF DEATH: COUNTY Balto — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sparks | LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sparks
STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) Andrew (Last) Daughton Jr.

4. DATE OF DEATH: (Month) Sept (Day) 7 (Year) 19 53

5. SEX: M

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 7-19-53

9. AGE last birthday: yrs. | If under 1 year: Months | Days 18 | If under 24 hrs: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Balto Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard A. Daughton

14. MOTHER'S MAIDEN NAME: Ruth Ringgold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Father — Home

### 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

768.0 **Immediate cause** (a) Septicaemia, probable cause

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) was numerous excoriations about the buttocks and lower abdominal wall covered with a purulent exudate.

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy , Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

A. M. Francis M.D. Baltimore, Md. 9/7/53

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 9-8-53 | NAME OF CEMETERY OR CREMATORY Stevenson A.M.E. | LOCATION (City, town, or county) Sparks (State) Md.

DATE REC'D BY LOCAL REG. 8 Sept 1953 | REGISTRAR'S SIGNATURE Anne Annis Rad Mac Fae

24. FUNERAL DIRECTOR | ADDRESS J. Scott Brooks, Sparks, Md.

10731+405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AIA

SEP 10 19..
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Towson
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Armacost Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (14)
STREET ADDRESS (If rural give location) 406 Woodlawn Rd.

3. NAME OF DECEASED: (Type or Print) (First) Grace (Middle) L. (Last) Deal

4. DATE OF DEATH: (Month) Sept (Day) 1 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: April 6, 1880

9. AGE last birthday: 73 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Nursery Nursery

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Conago N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin Fillmore Deal

14. MOTHER'S MAIDEN NAME: Alice Stratton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mrs Grace Smith 4907 Potomac Ave Washington D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Scleroderma DUE TO

Antecedent causes (b) DUE TO
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 7, 1951, to Sept 1, 1953, that I last saw the deceased alive on Sept 1, 1953, and that death occurred at 10:35 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) William L. Hedrick MD ADDRESS 5006 Roland Ave Balto 10 DATE SIGNED 9/2/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Sept 4 1953

NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery

LOCATION (City, town, or county) Pikesville (State) Balto. Md.

DATE REC'D BY LOCAL REGISTRAR 9/3/53

REGISTRAR'S SIGNATURE a (w) Frederick JT

24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.

ADDRESS 4905 York Rd

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: COUNTY Balto — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Perry Hall | LENGTH OF STAY (In this place) 11 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3727 Joppa Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Raspeburg X
STREET ADDRESS (If rural give location) 3727 Joppa Rd.

| 3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|
| Charles L. Deckert | 9 2 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 2nd 1884 | 68 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Truck farmer | Own farm | Balto. Co. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Julius Deckert | Mary Krach |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | None | 14 yrs. C. L. Deckert 3727 Joppa Rd. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) CORONARY THROMBOSIS — 2 HRS.

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from SEPT. 2, 1953, to SEPT. 2, 1953, that I last saw the deceased alive on SEPT. 2, 1953, and that death occurred at 2:15 A.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) ADDRESS | DATE SIGNED |
|---|---|---|
| Michael C. Barry, M.D. | 304 GARDEN RD., TOWSON 4, MD. | Sept. 2, 1953 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/3/53 | St. Johns Lutheran | Balto. Co. Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-4-53 | [signature] | Lansdale Funeral Home | 7401 Belair Rd. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

Dr. Barry
304 Garden Rd

RECEIVED
SEP 16 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]63

# CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Sparrows Pt. X
MARYLAND LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2328 Sparrows Pt. Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sparrows Point X
STREET ADDRESS (If rural give location) 2328 Sparrows Pt. Rd.

3. NAME OF DECEASED: (Type or Print) (First) Frank (Middle) (Last) Dennis

4. DATE OF DEATH: (Month) Sept. (Day) 11 (Year) 53

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Aug. 25, 1889

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Shearman

10b. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel

11. BIRTHPLACE (State or foreign country): Baltimore Co., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Bass ~~Dennis~~ Dennis

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-07-1642

17. INFORMANT & ADDRESS: Clarence R. Dennis, 2328 Sparrows Pt. Rd.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

177X
Immediate cause (a) Carcinomatosis (Generalized) — Interval between Onset And Death 1947-1953

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Malignancy of Prostate — 1 year
DUE TO (c) Obesity — 20 years

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: June 1947

19b. MAJOR FINDINGS OF OPERATION: Malignancy of Prostate

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947, to Sept 11, 1953, that I last saw the deceased alive on Sept 11, 1953, and that death occurred at 12.45 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) Morris A. Jacobs - MD ADDRESS 1010 North Point Rd DATE SIGNED 9/11/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 9/14/1953

NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery

LOCATION (City, town or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR 9/14/53

REGISTRAR'S SIGNATURE C. W. Redrick M.H.

24. FUNERAL DIRECTOR Edsworth Ambrose ADDRESS 4600 Liberty Hghts. Ave. 7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 34

# CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Catonsville LENGTH OF STAY (in this place) 5yr 3mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 2211 Orem Ave

3. NAME OF DECEASED: (Type or Print) (First) SOPHIA (Middle) M (Last) ECKERT

4. DATE OF DEATH: (Month) Sept (Day) 3 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: Nov 14 1868

9. AGE last birthday: 1111 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: (?) CALEB STAINE

14. MOTHER'S MAIDEN NAME: RACHE STAINE (CROSS) 2211 OREM ST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: MRS A BASSARD BALTO MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 443X

Immediate cause (a) Generalized Arteriosclerosis

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) with Hypertension and

DUE TO

(c) Cardiac Enlargement

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-5, 19.47, to 9-3, 19.53, that I last saw the deceased alive on 9-3, 19.53, and that death occurred at 11 P m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Spring Grove Hospital Catonsville Md by J.R. Brown, MD 9/3/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 9/9/53

NAME OF CEMETERY OR CREMATORY Baltimore Cem.

LOCATION (City, town, or county) Balto., Md. (State)

DATE REC'D BY LOCAL REG. 9-9-53

REGISTRAR'S SIGNATURE A.W. Hedrich dmr.

24. FUNERAL DIRECTOR: Wm. J. Vickery & Sons ADDRESS Balto. 17, Md.

VS. A15 1 T

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 53

# CERTIFICATE OF DEATH

Reg. Dist. No. 41

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 53 Dundalk
MARYLAND LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 85 Dundalk Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dundalk 53
STREET ADDRESS (If rural give location) 85 Dundalk Ave.

3. NAME OF DECEASED: (Type or Print) (First) WANETA (Middle) (Last) ELLIOTT

4. DATE OF DEATH: (Month) Sept. (Day) 16, (Year) 19 53

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced

8. DATE OF BIRTH: April 30, 1872

9. AGE last birthday: yrs. 81
IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John H. Spence

14. MOTHER'S MAIDEN NAME: Annie R. Burkins

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Ann K. Gehr - 18 Portship Rd., Dundalk, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause (a) Cerebral Hemorrhage

DUE TO (b) Hypertensive Cardio Vascular Disease

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)

Interval Between Onset And Death: 2 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 14, 1953, to Sept. 16, 1953, that I last saw the deceased alive on Sept. 15, 1953, and that death occurred at 5:30 A, from the causes and on the date stated above.

SIGNATURE (Degree or title) M. Davis M.D.

ADDRESS Dundalk Md

DATE SIGNED Sept 17 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 9/19/53

NAME OF CEMETERY OR CREMATORY Loudon Park Cem.

LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REGISTRAR 9-17-53

REGISTRAR'S SIGNATURE A W Bussard

24. FUNERAL DIRECTOR Wm. J. Pickner & Sons

ADDRESS Balto 17, Md.

VS 4-51

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY BALTIMORE — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CATONSVILLE — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS PARADISE NURSING HOME

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE MD
STREET ADDRESS (If rural, give location) 504 N. ELLWOOD AVE

3. NAME OF DECEASED (Type or Print): (First) CATHERINE (Middle) (Last) ERDMAN
4. DATE OF DEATH: (Month) SEPT (Day) 11 (Year) 1953

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | WIDOWED | AUG 21, 1868 | 85 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? BARON
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT AND ADDRESS: EVELYN ERDMAN 504 N. ELLWOOD AV

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Thrombosis | 12 hrs |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| 332 | (c) Arteriosclerosis, generalized, severe | Unknown |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Osteoarthritis, severe; Decubitus ulcer — Unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-22, 1953, to 9-12, 1953, that I last saw the deceased alive on 9-11, 1953 and that death occurred at 1:10 A m., from the causes and on the date stated above.

SIGNATURE: Stilson Cox Mayness (Degree or title) MD — ADDRESS: Catonsville 28, Md. — DATE SIGNED: 9-12-53

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | SEPT 15, 1953 | OAK LAWN | COLGATE MD |

DATE REC'D BY LOCAL REG. 9/14/53 — REGISTRAR'S SIGNATURE: C. W. Hedrick M.D. — 24. FUNERAL DIRECTOR: ULLRICH FUNERAL HOME — ADDRESS: 2112 PUNDALK AV

Item 8 - Zahnlb 158 - 9/15/53 mnk

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 7-30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especiaportant. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): HENRY GEORGE FAUPEL

2. DATE OF DEATH: Sept. 2. 1953

3. PLACE OF DEATH: A. Baltimore City, Maryland (Inst.)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ridgeway Manor Nursing Home 5743 Edmondson Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limit write RU (A) and give city): Baltimore 12
D. STREET ADDRESS (If rural, give location): 1130 E. Belvedere Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | May. 5. 1864 | 89 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Banker- Retired 1925

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Faupel

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Clara M. Faupel (Wife) ADDRESS: 1130 E. Belvedere Ave

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral Arteriosclerosis — 1 year

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Anterior spinal artery thrombosis — 6 months; Bladder infection — 5 months; Arterio sclerotic heart disease — years

| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II | 20. AUTOPSY? |
|---|---|---|---|
| | | | YES ☐ NO ☒ |

| 21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug 1, 1953 *to* Sept 2, 1953 *that I last saw the deceased alive on* 9/1, 1953 *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jay Futterman | 2 E. Read St. | 9 3 53 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 4. 1953 | Baltimore Cem. | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 4 | Victor F. Henry mnk | HENRY SANDER & SONS. INC. Baltimore Md. |

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
LENGTH OF STAY (in this place) 51 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS at home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
STREET ADDRESS (If rural, give location) 1247 Sulphur Spring Rd

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Allen (Last) Fillmore
4. DATE OF DEATH: (Month) Sept (Day) 4 (Year) 1953

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Unknown
9. AGE last birthday: 69 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Lt. Davis Fledwell
14. MOTHER'S MAIDEN NAME: Hannah Alkire

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY No.: No
17. INFORMANT: R.F. Fillmore Son 1211-40 Sulphur Spring Rd Balto

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Extensive Arteriosclerosis | ? |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Terminal Cerebral Hemorrhage | ? |
| | (c) | |

443

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: No
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1, 1953, to 9/4, 1953, that I last saw the deceased alive on 9/3, 1953, and that death occurred at 6:05 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John E Healy M.D. ADDRESS: Catonsville Md DATE SIGNED: 9/4/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 9/7/53 | NAME OF CEMETERY OR CREMATORY: Woodlawn | LOCATION (City, town, or county): Woodlawn (State):

DATE REC'D BY LOCAL REG.: September 5 1953 | REGISTRAR'S SIGNATURE: R.W.

24. FUNERAL DIRECTOR: Edward Mowell Jr. ADDRESS: Baltimore

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS-A15A

1. PLACE OF DEATH: COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Fort Howard
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Veterans Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 407 Jack Street

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) E. (Last) FIORI

4. DATE OF DEATH: (Month) September (Day) 1 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 2/19/33

9. AGE Last birthday: 20 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gen. Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Fiori Co.

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry W.

14. MOTHER'S MAIDEN NAME: Myrtle M. Kirby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Family - Same

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

4 Immediate cause (a) Confluent bronchopneumonia

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* X, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐

SIGNATURE: William V. Smith (Degree or title) ADDRESS: 700 Fleet Street, Baltimore, Md. DATE SIGNED: 9/2/53

23. BURIAL, CREMATION, REMOVAL (Specify): B | DATE THEREOF: 9/5/53 | NAME OF CEMETERY OR CREMATORY: Holy Cross | LOCATION (City, town, or county) (State): Baltimore

DATE REC'D BY LOCAL REG.: SEP 4 1953 | REGISTRAR'S SIGNATURE: L

24. FUNERAL DIRECTOR ADDRESS: James L. McCully - 130 E. Fort Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (53-70)

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fort Howard
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 11-11-4
STREET ADDRESS (If rural give location) 1914 Harlem Avenue

3. NAME OF DECEASED: (First) VAN (Middle) (NMI) (Last) FLOYD
4. DATE OF DEATH: (Month) September (Day) 1 (Year) 19 53
5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 6-15-12
9. AGE last birthday: 41 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Steel mill
11. BIRTHPLACE (State or foreign country): Newberry, South Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Evans Floyd
14. MOTHER'S MAIDEN NAME: Anna Williams
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW II
16. SOCIAL SECURITY No.: 248-28-1440
17. INFORMANT & ADDRESS: Clin.Rec.,Vet.Adm.Hosp.,Ft.Howard,Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) TUBERCULOSIS OF LUNG, FAR ADVANCED, ACTIVE — 1 YEAR
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) TUBERCULOUS PERICARDITIS WITH EFFUSION — UNKNOWN
DUE TO

(c) TUBERCULOUS LEPTOMENINGITIS — UNKNOWN

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 27, 1953, to Sep. 1, 1953, [illegible] and that death occurred at 11:01 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
PERRY STEARNS, M. D. Perry Stearns M.D. VAH, FORT HOWARD, MARYLAND 9-4-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9-7-53 — NAME OF CEMETERY OR CREMATORY Hannah's Cemetery — LOCATION (City, town, or county) (State) Newberry, South Carolina

DATE REC'D BY LOCAL REGISTRAR Sept 5, 1953 — REGISTRAR'S SIGNATURE R.W.

24. FUNERAL DIRECTOR — ADDRESS
Samuel W. Sullivan, Jr. Funeral Home
1011 N. Arlington Ave., Baltimore 17, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 42

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Baltimore — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rosemont — LENGTH OF STAY (In this place): X
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 3000 Alabama Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rosemont X
STREET ADDRESS (If rural, give location): 3000 Alabama Ave.

3. NAME OF DECEASED (Type or Print): (First) Clarence (Middle) R. (Last) Frederick

4. DATE OF DEATH: (Month) Sept. (Day) 11 (Year) 1953

5. SEX: M — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): M — 8. DATE OF BIRTH: 8/8/1898 — 9. AGE last birthday: 55 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. Electric Ref. — 10b. KIND OF BUSINESS OR INDUSTRY: Gas & Elec. Co — 11. BIRTHPLACE (State or foreign country): Baltimore Md. — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William E. Frederick — 14. MOTHER'S MAIDEN NAME: Elsie L. Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): I — 16. SOCIAL SECURITY NO.: 212.05.3124 — 17. INFORMANT: Helen V. Frederick 3000 Alabama Ave. Rosemont, Balto. Co. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

5771

Immediate cause (a) Chr. Myocarditis — Interval between onset and death: a/o 1953

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Emphysema — 1950

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 7, 1953 to Sept 11, 1953 that I last saw the deceased alive on Sept 11, 1953 and that death occurred at 11:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Paul Brown M.D. — ADDRESS 3602 Liberty Hgts Ave. Balto. 15 Md. — DATE SIGNED 9/12/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Sept. 15, 1953 — NAME OF CEMETERY OR CREMATORY: Baltimore National — LOCATION (City, town, or county) (State): Baltimore Md.

DATE REC'D BY LOCAL REG. 9/14/53 — REGISTRAR'S SIGNATURE: W W Heinrich — 24. FUNERAL DIRECTOR: John T. Stansbury — ADDRESS: 2700 Edmondson Ave.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

# CERTIFICATE OF DEATH

Reg. Dist. No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: Lansdowne
LENGTH OF STAY (in this place): 7 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 130 3rd Ave

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Md. — COUNTY: Bal
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lansdowne
STREET ADDRESS (If rural give location): 130 3rd Ave

**3. NAME OF DECEASED:** (First) Helen (Middle) S. (Last) Galloway

**4. DATE OF DEATH:** (Month) 9 (Day) 28 (Year) 1953

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED:** (Specify) Divorced

**8. DATE OF BIRTH:** 3/17/1906

**9. AGE last birthday:** 47 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired: House Work

**10b. KIND OF BUSINESS OR INDUSTRY:** at Home

**11. BIRTHPLACE** (State or foreign country): Baltimore

**12. CITIZEN OF WHAT COUNTRY?** U S A

**13. FATHER'S NAME:** Benjamin Young

**14. MOTHER'S MAIDEN NAME:** Nellie Donnelly

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) —
(If Yes, give war or dates of service) —

**16. SOCIAL SECURITY No.:** —

**17. INFORMANT & ADDRESS:** Mrs Joseph M. Valcourt 130 3rd ave

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause: 171 X
(a) Carcinoma of Cervix, Squamous
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

Interval Between Onset And Death: 2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** July '53
**19b. MAJOR FINDINGS OF OPERATION:** Radium Therapy for Stage III Carcinoma Cervix.
**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 53, to Sept 28 19 53 that I last saw the deceased alive on 9/28/, 1953, and that death occurred at 1030 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title): James H. Shell Jr. M.D.
ADDRESS: 214 Medical Arts Bldg Balto Md
DATE SIGNED: 9/29/53

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial
DATE THEREOF: 10/1/53
NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
LOCATION (City, town, or county) (State): 4300 Old Frederick Rd.

DATE REC'D BY LOCAL REGISTRAR: 10-2-53
REGISTRAR'S SIGNATURE:

**24. FUNERAL DIRECTOR** ADDRESS: John J. Cowan & Son Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. C-73 38

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5 Centre Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson
STREET ADDRESS (If rural give location) 5 Centre Road

3. NAME OF DECEASED: (Type or Print) (First) DOROTHY (Middle) MAYES (Last) GARDNER

4. DATE OF DEATH: (Month) (Day) (Year) September 26, 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: October 13, 1904

9. AGE last birthday: 48 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hugh Mayes

14. MOTHER'S MAIDEN NAME: Ellen Allen

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) None

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Kenneth Gardner, Jr., Towson, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174X

Immediate cause (a) Carcinoma of Liver (metastatic)

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Primary Carcinoma of Uterus + Rt. Ovary

DUE TO (c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 10, 1953 to Sept 26, 1953, that I last saw the deceased alive on Sept 26 1953, and that death occurred at 5:25 P.m. from the causes and on the date stated above.

SIGNATURE Laurence C. Foster (Degree or title) M.D. ADDRESS 6805 York Rd DATE SIGNED 9/27/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Sept. 28, 1953 | NAME OF CEMETERY OR CREMATORY Blandford Cemetery | LOCATION (City, town, or county) Petersburg, Virginia (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 28, 1953 | REGISTRAR'S SIGNATURE Mabel C. Gray

24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland ADDRESS

RECEIVED
SEP 29 1953
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 50

**1. PLACE OF DEATH**
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Catonsville
LENGTH OF STAY (In this place): 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 345 Greenlow Road

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Catonsville
STREET ADDRESS (If rural, give location): 345 Greenlow Road.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Daniel | Lorenz | Getz | Sept. | 1, | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | white | Married | Sept. 3, 1890 | 62 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Salesman | Dental Supplies | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Getz | Mary Schwab |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No — None | 214-01-3539 | Anna E Getz 345 Greenlow Road |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Metastatic Ca of Lung & Brain — 3 mos.

150X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Ca of Esophagus — 8 mos.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 5-6, 1953, to 9-1, 1953, that I last saw the deceased alive on 8-31, 1953, and that death occurred at 9:30 A.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Wilbur K. Gallager | M.D. | Catonsville 28, Md | 9-1-53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 4, 1953 | Western Cemetery | Baltimore, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| 9-1-53 | [signature] | Geo. L. Schwab 210 Frederick Ave. Balto., Md. |

RECEIVED
SEP 3 1
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 0 35

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort Howard
LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 700 E. Baltimore Street

3. NAME OF DECEASED: (Type or Print) (First) ANTONIO (Middle) J. (Last) GIRARD

4. DATE OF DEATH: (Month) Sept. (Day) 26 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 5/7/06

9. AGE last birthday: 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Textile worker

10b. KIND OF BUSINESS OR INDUSTRY: Textile Industry

11. BIRTHPLACE (State or foreign country): Lewiston, Maine

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph

14. MOTHER'S MAIDEN NAME: Leva Gerdais

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT & ADDRESS: Clin.Rec., Vet.Adm.Hosp., Ft.Howard, Md.

18. MEDICAL CERTIFICATION

581.1

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) LAENNEC'S CIRRHOSIS — Interval Between Onset And Death: UNK.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 16, 19 53, to Sept. 26, 19 53, that I last saw the deceased alive on [illegible], and that death occurred at 10:30 A.M., from the causes and on the date stated above.

SIGNATURE A.E. JUDD, M.D. (Degree or title) ADDRESS VAH, Fort Howard, Md. DATE SIGNED 9/26/53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE THEREOF 9-28-53 NAME OF CEMETERY OR CREMATORY St. Peters Cemetery LOCATION (City, town, or county) Lewiston, Maine (State)

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Howard Blight Funeral Home ADDRESS 6009 Harford Rd. Baltimore, Maryland Mildred I. Blight

SHIP TO: ROLAND PINETTE FUNERAL HOME, 870 BARTLETT, LEWISTON, MAINE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-15

**1. PLACE OF DEATH**
COUNTY: BALTIMORE — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: TOWSON
LENGTH OF STAY (in this place): 7 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 5 Willow Ave

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: MD — COUNTY: BALTO.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: TOWSON
STREET ADDRESS (If rural, give location): 5 WILLOW AVE

**3. NAME OF DECEASED** (Type or Print): (First) EDWARD (Middle) LUDWIG (Last) GOHR

**4. DATE OF DEATH**: (Month) Sept. (Day) 14 (Year) 1953

**5. SEX**: MALE

**6. COLOR OR RACE**: WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): MARRIED

**8. DATE OF BIRTH**: Dec. 11-1889

**9. AGE last birthday**: 63 yrs. — If under 1 year: Months / Days / Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): MECHANIC

**10b. KIND OF BUSINESS OR INDUSTRY**: AUTOMOBILE

**11. BIRTHPLACE** (State or foreign country): MARYLAND

**12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME**: OTTO GOHR

**14. MOTHER'S MAIDEN NAME**: HENRIETTA KOESTING

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service): NO

**16. SOCIAL SECURITY NO.**: 215-05-9926

**17. INFORMANT AND ADDRESS**: M. EMMA GOHR 5 Willow Ave

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334X **Immediate cause** (a) Coronary thrombosis - recurrent — Interval Between Onset and Death: 12 mos

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cerebral arteriosclerosis — 12 mos

(c) Generalized arteriosclerosis severe — 6 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: (1) Bronchial asthma (2) Prostatism (3) Renal insufficiency

**19a. DATE OF OPERATION** | **19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/27, 1953, to 9/13, 1953, that I last saw the deceased alive on 9/13, 1953, and that death occurred at 5:30 P m., from the causes and on the date stated above.

SIGNATURE: Donald L. Somerville — (Degree or title) M.D. — ADDRESS: 25 W. Pa. Ave Towson 4 Md. — DATE SIGNED: 9/14/53

**23. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL — DATE: 9.17.53 — NAME OF CEMETERY OR CREMATORY: SALEM Lutheran — LOCATION (City, town, or county): CATONSVILLE (State): MD

DATE REC'D BY LOCAL REG. — REGISTRAR'S SIGNATURE

**24. FUNERAL DIRECTOR** — ADDRESS: D. Howard Strong 3707 W. North Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]7

# CERTIFICATE OF DEATH

Reg. Dist. No. 37

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lutherville X
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Greenspring Drive

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lutherville X
STREET ADDRESS (If rural give location) Greenspring Drive

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) WINFIELD (Last) GREB

4. DATE OF DEATH: (Month) Sept. (Day) 30, (Year) 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower

8. DATE OF BIRTH: Sept. 13, 1880

9. AGE Last birthday: 73 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Greb

14. MOTHER'S MAIDEN NAME: Anna Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) None

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: George Dedal, Lutherville, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X

Immediate cause (a) Pneumonia, Lobar. — Interval Between Onset And Death: 5 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Malnutrition — Interval Between Onset And Death: Unk.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/16/53, 19..... to 9/30/53, 19..... that I last saw the deceased alive on 9/29/53, 19..... and that death occurred at 8.10 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Bennett A. Glaser M.D. ADDRESS Lutherville DATE SIGNED 10/1/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct. 2, 1953 NAME OF CEMETERY OR CREMATORY Sater's Cemetery LOCATION (City, town, or county) (State) Lutherville, Balto. Co., Md.

DATE REC'D BY LOCAL REGISTRAR 2 October 1953 REGISTRAR'S SIGNATURE Anne Armistead MacRae

24. FUNERAL DIRECTOR ADDRESS John Burns' Sons, Towson, Maryland

RECEIVED
OCT 5 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 42

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY BALTIMORE — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HALETHORPE
LENGTH OF STAY (in this place) 2 MO.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1734 WINANS AVE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND — COUNTY BALTO.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HALETHORPE
STREET ADDRESS (If rural give location) 1734 WINANS AVE.

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) W. (Last) HALL.

4. DATE OF DEATH: (Month) SEPT. (Day) 3 (Year) 1953

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: APR. 14, 1890

9. AGE last birthday: 63 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: TIRE BUILDER

10b. KIND OF BUSINESS OR INDUSTRY: SCHENUIT TIRE CO.

11. BIRTHPLACE (State or foreign country): PENN.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WILLIAM HALL.

14. MOTHER'S MAIDEN NAME: ADELINE C. CARNER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO. (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 213-05-6500

17. INFORMANT & ADDRESS: RUSSELL HALL 1734 WINANS AVE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO: 163X Carcinoma of Lung.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO:

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/1, 1953 to 9/2, 1953, that I last saw the deceased alive on 9/2, 1953, and that death occurred at 12 05 PM from the causes and on the date stated above.

SIGNATURE John C. Neely M.D. (Degree or title) ADDRESS Halethorpe DATE SIGNED 9/4/53

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL — DATE THEREOF SEPT. 5, 1953 — NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEM. — LOCATION (City, town, or county) BALTIMORE, MARYLAND (State) — ADDRESS

DATE REC'D BY LOCAL REGISTRAR 9/4/53 — REGISTRAR'S SIGNATURE A W Hallock

24. FUNERAL DIRECTOR Joseph Timbrook Jr. 1320 Sulphur Spring Rd.

VS. A15 (T)

JS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 71

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A1E

1. PLACE OF DEATH:
COUNTY: BALTIMORE — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: CATONSVILLE
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 125 FORREST DRIVE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: MARYLAND — COUNTY: BALTO.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CATONSVILLE
STREET ADDRESS (If rural give location): 125 FORREST DRIVE

3. NAME OF DECEASED: (First) ANNIE (Middle) M (Last) HAMMERBACHER
4. DATE OF DEATH: (Month) SEPT (Day) 30 (Year) 19 53

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: OCT:15:1864
9. AGE last birthday: 88 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): BALTIMORE MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: WILLIAM SCREIBER
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO.
(If Yes, give war or dates of service): **
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT & ADDRESS: WILLIAM SCREIBER. 4405 Leeds Ave

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause: (a) Myocardial Infarction — Interval Between Onset And Death: 2 Days.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1947, to Sept 30, 1953, that I last saw the deceased alive on Sept 24 1953, and that death occurred at 9:30 A.M., from the causes and on the date stated above.
SIGNATURE: [illegible] (Degree or title) — ADDRESS: 1118 St. Paul St. Baltimore 2, Md. — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE THEREOF: SEPT:3:53
NAME OF CEMETERY OR CREMATORY: LOUDON PARK CEMETERY
LOCATION (City, town, or county) (State): BALTIMORE MARYLAND
DATE REC'D BY LOCAL REGISTRAR: 9/2/53
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR — ADDRESS: F. B. Wippert & Sons

F.B.WIPPERT & SON 1300 Eutaw Pl.17

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 31

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, Reisterstown
LENGTH OF STAY (in this place): 35 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Hanover Pike & Butler Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Reisterstown -- Rural
STREET ADDRESS (If rural, give location): Hanover Pike & Butler Road

3. NAME OF DECEASED (Type or Print): (First) Herbert (Middle) (Last) Hammond

4. DATE OF DEATH: (Month) Sept. (Day) 13, (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov. 13, 1875

9. AGE last birthday: 77 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer -- retired owner

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Anne Arundel County, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Thomas Hammond

14. MOTHER'S MAIDEN NAME: Camsadel Lucinda Shipley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Anna Hammond Coe, 21 Union Street, Bridgewater, Mass.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Angina Pectoris — Interval between onset and death: 8 yrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis

(c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-1-30, 19..., to 9-13-53, 19..., that I last saw the deceased alive on 9-13-53 and that death occurred at 5:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James L. Gaffell M.D. Reisterstown Md. 9-13-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 9 - 16 - 53

NAME OF CEMETERY OR CREMATORY: All Saints

LOCATION (City, town, or county) (State): Reisterstown, Md.

DATE REC'D BY LOCAL REG. 9/14/53

REGISTRAR'S SIGNATURE: W. S. Hemis

24. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. — ADDRESS: 1900 Eutaw Place, Baltimore, Md.

M. B. Mitchell

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

COUNTY Baltimore, MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Ft. Howard

LENGTH OF STAY (in this place) 35 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE Maryland COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore

STREET ADDRESS (If rural give location) 402 Rock Glen Road

**3. NAME OF DECEASED:** (Type or Print) (First) Thomas (Middle) A (Last) Heagerty

**4. DATE OF DEATH:** (Month) September (Day) 4, (Year) 19 53

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Married

**8. DATE OF BIRTH:** 1-29-79

**9. AGE last birthday:** 74 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired: Chief-Fire Dept.

**10b. KIND OF BUSINESS OR INDUSTRY:** Retired

**11. BIRTHPLACE** (State or foreign country): Baltimore, Maryland

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Michael J. Heagerty

**14. MOTHER'S MAIDEN NAME:** Mary E. Dunn

**15 WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) Yes (If Yes, give war or dates of service) 6-5-02 to 6-4-06

**16. SOCIAL SECURITY No.:** None

**17. INFORMANT & ADDRESS:** Clin.Rec.,Vet.Adm.Hosp., Ft. Howard, Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

450.0 Immediate cause (a) GENERALIZED ARTERIOSCLEROSIS — UNKNOWN

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

**11. OTHER SIGNIFICANT CONDITIONS** Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT SUICIDE HOMICIDE** (Specify) **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) VA m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 31, 19 53, to Sept. 4, 19 53, that I last saw the deceased alive on [illegible] and that death occurred at 9:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) J.A. BARONOWSKI, M.D. ADDRESS VAH, Fort Howard, Md. DATE SIGNED 9-4-53

**23. BURIAL, CREMATION, REMOVAL** (Specify) Burial DATE THEREOF Sept. 8/53 NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR 9/8/53 REGISTRAR'S SIGNATURE C.W. Hedrich M.H.

**24. FUNERAL DIRECTOR** Harry H. Fitzke ADDRESS 4101 Edmondson Ave., Baltimore, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 32

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8346 Ridgely Oak Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimor
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (
STREET ADDRESS (If rural give location) 8346 Ridgely Oak Rd.

3. NAME OF DECEASED: (First) George (Middle) Edwin (Last) Heckner
4. DATE OF DEATH: (Month) Sept. (Day) 3 (Year) 1953

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: April 16 1917
9. AGE last birthday: 36 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Guard
10b. KIND OF BUSINESS OR INDUSTRY: Glen L. Martin
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Otto Heckner
14. MOTHER'S MAIDEN NAME: Annie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) WorldWarII
16. SOCIAL SECURITY NO.: 214-01-8403
17. INFORMANT & ADDRESS: Mrs. Madge Heckner-Wife-8346RidgelyRd

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Carcinomatosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Adenocarcinoma of Colon — 11 mos.

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Oct 1952
19b. MAJOR FINDINGS OF OPERATION: Adenocarcinoma Colon.
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct ....., 19 52, to Sept 3, 19 53, that I last saw the deceased alive on May 28, 19 53, and that death occurred at 5:20 a.m., from the causes and on the date stated above.

SIGNATURE Lester A. Hall (Degree or title) M.D. ADDRESS 1039 St. Paul St. DATE SIGNED Sept 3 1953.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 8, 1953
NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.
LOCATION (City, town, or county) (State) Windsor Mill Rd. Md.

DATE REC'D BY LOCAL REGISTRAR September 5. 1953
REGISTRAR'S SIGNATURE R.W.
24. FUNERAL DIRECTOR. ADDRESS Krause Funeral Home 1216S. CharlesSt.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5353

# CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Summit & Smithwood Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ~~Balto~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Catonsville~~
STREET ADDRESS (If rural give location) 3614 Kimble Road

3. NAME OF DECEASED: (Type or Print) (First) Mrs. (Middle) Anna Barbara (Last) Hendrickson
4. DATE OF DEATH: (Month) Sept (Day) 2 (Year) 1953
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: June 10, 1872 ? approx
9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): at home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tiffin, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Catherine?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Baltimore, 4, Md. Mrs. Roy Buress, 502 Stratford Court

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) Generalized Arterio Sclerosis
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving riss to the above cause stating the underlying cause last. (b) DUE TO
(c)
Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Heat Exhaustion

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 Aug, 1953, to 2 Sept, 1953, that I last saw the deceased alive on 1 Sept, 1953, and that death occurred at 5:15 AM from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. Zk Smith M.D. 1707 Edmondson Ave. Catonsville 28 md 2 Sept 53

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial
DATE THEREOF Sept 5-1953
NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery.
LOCATION (City, town, or county) (State) Tiffin, Ohio
DATE REC'D BY LOCAL REGISTRAR 9/3/53
REGISTRAR'S SIGNATURE G W Hedrick
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, 5305 Harford Road.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Lot F. Hilterbrick MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]ville
LENGTH OF STAY (in this place) [illegible]
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6606 Cartwright Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE [illegible] COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN B [illegible] Parkville X
STREET ADDRESS (If rural, give location) 6606 Cartwright Rd.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) J. (Last) Hilterbrick
4. DATE OF DEATH (Month) Sept. (Day) 30, (Year) 53 19

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widow
8. DATE OF BIRTH: 5/14/1886
9. AGE last birthday: 67 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? Swasler
14. MOTHER'S MAIDEN NAME: ? Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Francis Swasler 6606 Cartwright

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary Thrombosis — Interval between onset and death: Immediate

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Hyper Tensive Cardio Vascular Disease — Interval between onset and death: 4 years.
(c) Congestive Heart failure — Interval between onset and death: 1 year.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from —, 1953, to 27 Sept., 1953, that I last saw the deceased alive on 27 Sept., 1953, and that death occurred at 9 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
2-October 53 5214 Raynor Rd James E. White M.D.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Oct. 3, 53
NAME OF CEMETERY OR CREMATORY: Balto. Cemtery
LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG. 10/1/53
REGISTRAR'S SIGNATURE: C W Hedrick
24. FUNERAL DIRECTOR: Paul A. H[illegible] ADDRESS: [illegible] Harford Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Dundalk 22
LENGTH OF STAY (In this place): 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 517 New Pittsburgh Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Virginia, COUNTY: Lunenberg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Meherrin
STREET ADDRESS (If rural, give location): Rt.1, Box 8A

3. NAME OF DECEASED (Type or Print): (First) John (Middle) (Last) Hinds
4. DATE OF DEATH: (Month) 9 (Day) 9 (Year) 53

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: April 6,1887
9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Self-employed
11. BIRTHPLACE (State or foreign country): Meherrin, Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Hinds
14. MOTHER'S MAIDEN NAME: Polly Holms

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT AND ADDRESS: Pinkey S. Hinds, Rt.1 Box 8A, Meherrin, Va.

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Myocarditis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

C. K. Davis MD - Alph No 1 [illegible] 9/7/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9/13/53 — NAME OF CEMETERY OR CREMATORY: Shilo Baptist — LOCATION (City, town, or county) (State): Meherrin, Virginia

DATE REC'D BY LOCAL REG: 9-11-53 — REGISTRAR'S SIGNATURE: A.W.Hedrich — 24. FUNERAL DIRECTOR — ADDRESS: Charles R. Law, 802 Madison Ave.

dmr.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 53

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
LENGTH OF STAY (in this place) 52
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wayne's Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore Md.
STREET ADDRESS (If rural give location) 3529 Liberty Heights Avenue

3. NAME OF DECEASED: (First) John (Middle) Neff (Last) Hinds
4. DATE OF DEATH: (Month) Sept (Day) 13 (Year) 1953

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 9-30-1883 | 69 yrs. | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Shoe Salesman | Shoe Co. | Baltimore Maryland | U.S.A. |

13. FATHER'S NAME: Charles Hinds
14. MOTHER'S MAIDEN NAME: Rachael Sumwalt

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | 217-07-8537 | MARY KATHERINE HINDS (WIFE) 3529 Liberty Heights Avenue |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause | (a) Carcinoma of the Colon | |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | DUE TO (b) with Metastases. | |
| | DUE TO (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1951 | Carcinoma of the Colon | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from July, 1953, to 13 Sept., 1953, that I last saw the deceased alive on 13 Sept, 1953, and that death occurred at 11:10 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) M. D. ADDRESS 1707 Edmondson Ave, Catonsville 28 Md. DATE SIGNED 13 Sept 53

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 16, 1953 | Woodlawn Cemetery | Woodlawn Maryland |

DATE RECD BY LOCAL REGISTRAR 9/14/53 — REGISTRAR'S SIGNATURE C. W. Hedrick M.D.

24. FUNERAL DIRECTOR Ellsworth Armacost — ADDRESS 4600 LIBERTY HEIGHTS AVENUE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Woodlawn
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 2109 Cresson Road

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Woodlawn
STREET ADDRESS (If rural, give location): 2109 Cresson Road

| 3. NAME OF DECEASED: (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| John | Lee | Hong | Sept | 17th | 1953 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Yellow | Single | Sept-1-1929 | 24 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sheet Metal Worker | | Baltimore, Maryland | U.S.A. |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Charles Hong | Shee Chin |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No — None | | Mrs. Robert Lew (sister) Woodlawn, Md. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

591X

Immediate cause (a) Uremia

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Nephritis - Nephrotic Syndrome

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| M. | | |

22. I hereby certify that I attended the deceased from August 31, 1953 to Sept 17, 1953, that I last saw the deceased alive on Sept 17, 1953, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

| SIGNATURE | (DEGREE OR TITLE) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Joseph C Matchar | M.D. | 3623 Liberty Hghts Ave | Sept 17, 1953 |

| 23. BURIAL, CREMATION, REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept-19-1953 | Lorraine Cemetery | Woodlawn, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-18-53 | A.W.Hedrich | Stewart & Mowen Co. | 108 W. North Ave. |

dmr.

City #1.

Item #8 - Film B157 - 9/8/53 - Mmb

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 ...789

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
COUNTY: Balto. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Catonsville
LENGTH OF STAY (in this place): 7
HOSPITAL OR INSTITUTION OR STREET ADDRESS: House in the Pines

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 1102 Wildwood Pkwy.

3. NAME OF DECEASED (Type or Print): (First) ROSE (Middle) (Last) LITSKOVITZ

4. DATE OF DEATH: (Month) Sept. (Day) 2, (Year) 19 53

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Dec. 24, 1878 1877

9. AGE last birthday: yrs. 75 | IF UNDER 1 YEAR: Months ... Days ... | IF UNDER 24 HRS.: Hours ... Min. ...

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Lodz, Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): none (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs. J. Donald Bish - 1102 Wildwood Pkwy.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause (a) Myocardial insufficiency

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease

DUE TO

(c)

Interval Between Onset And Death: ...

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 12, 1951 to Sept. 2, 1953, that I last saw the deceased alive on Sept. 2, 1953, and that death occurred at 10:00P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Dewey A. Kreger M.D. ADDRESS: 4116 Edmondson Avenue DATE SIGNED: Sept. 3, 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 9/4/53 | NAME OF CEMETERY OR CREMATORY: Lorraine Park Cem. | LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REGISTRAR: 9/3/53 | REGISTRAR'S SIGNATURE: a w Hedrick | 24. FUNERAL DIRECTOR: Wm. J. Dickener & Sons ADDRESS: Balto 17, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. ..

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY BALTO. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TOWSON
LENGTH OF STAY (in this place) 55
HOSPITAL OR INSTITUTION OR STREET ADDRESS 26 CAVAN DRIVE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY BALTO.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON 55
STREET ADDRESS (If rural give location) 26 CAVAN DRIVE

3. NAME OF DECEASED: (Type or Print) (First) ROBERT (Middle) ALLEN (Last) JACKSON

4. DATE OF DEATH: (Month) SEPT. (Day) 9 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: 2-12-1951

9. AGE Last birthday: 2 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): BALTO. MD

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: CHARLES H. JACKSON JR.

14. MOTHER'S MAIDEN NAME: MARY VIRGINIA WISE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: CHARLES H. JACKSON ABOVE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

156.1

Immediate cause (a) Bronchopneumonia, both lungs. — Interval Between Onset And Death: 2 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Tumor, probably neuroblastoma, of liver, with lung metastases — 5 months

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Emaciation

19a. DATE OF OPERATION: April 24 1953

19b. MAJOR FINDINGS OF OPERATION Tumor of liver

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 19..., to ..., 19..., that I last saw the deceased alive on ..., 19..., and that death occurred at 8:30 P.M., Sept 9, 1953, from the causes and on the date stated above.

Attended by Dr. Terry Burger from April 16/1953. Numerous visits

SIGNATURE Wm. C. Stefley Jr. (Degree or title) M.D. ADDRESS 3301 N. Charles St. Baltimore 18 DATE SIGNED Sept. 10, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL — DATE THEREOF 9-11-1953 — NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL — LOCATION (City, town, or county) BALTO. CO. (State) MD.

DATE REC'D BY LOCAL REGISTRAR 9/10/53 — REGISTRAR'S SIGNATURE A W Hedrich

24. FUNERAL DIRECTOR H.W. JENKINS & SONS CO. ADDRESS 4905 YORK RD.

Dr Burger is now on vacation

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 38

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information ■refully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

VS. A15

**1. PLACE OF DEATH:**
COUNTY BALTIMORE — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 55 TOWSON
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 601 WILTON ROAD

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE MARYLAND — COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TOWSON
STREET ADDRESS (If rural give location) 601 WILTON ROAD

**3. NAME OF DECEASED: (Type or Print)** (First) ROSA (Middle) (Last) JAENICKE

**4. DATE OF DEATH:** (Month) SEPT. (Day) 5, (Year) 1953

**5. SEX:** FEMALE

**6. COLOR OR RACE:** WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** MARRIED

**8. DATE OF BIRTH:** MARCH 31. 1872

**9. AGE last birthday:** 81 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY:** AT HOME

**11. BIRTHPLACE** (State or foreign country): FINLAND

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** UNKNOWN

**14. MOTHER'S MAIDEN NAME:** UNKNOWN

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No — (If Yes, give war or dates of service) NONE

**16. SOCIAL SECURITY NO.:** NONE

**17. INFORMANT & ADDRESS:** MRS. M. M. EDWARDS — 601 WILTON ROAD TOWSON 4, MD.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

4/22/1

Immediate cause (a) Cardiac Failure (Myocarditis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☐

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1951, to SEPT. 5, 1953, that I last saw the deceased alive on SEPT. 5, 1953, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

SIGNATURE Laurence C. Post (Degree or title) M.D. — ADDRESS 6805 York Rd — DATE SIGNED 9/8/53

**23.** BURIAL, CREMATION, REMOVAL (Specify) BURIAL — DATE THEREOF SEPT. 10, 1953 — NAME OF CEMETERY OR CREMATORY ARLINGTON NATL. CEM. — LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA

DATE REC'D BY LOCAL REGISTRAR Sept. 9, 1953 — REGISTRAR'S SIGNATURE Mabel C. Gray

**24.** FUNERAL DIRECTOR John Burns' Sons, Towson, MD. — ADDRESS

BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct [illegible] is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Heathcote — LENGTH OF STAY (in this place) 57
HOSPITAL OR INSTITUTION OR STREET ADDRESS St Lukes Living Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Bal. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corbyesville Md X
STREET ADDRESS (If rural, give location)

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Oliver | Lawson | | Sept. | 14 | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | ? ? 1876 | 77 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Farmer | | Baltimore County | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wesley Johnson | Jane ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | | Thelma [illegible] |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio Valvular Disease — 4 mos 9 days

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from May 5, 1953, to Sept 14, 1953, that I last saw the deceased alive on Sept 10, 1953, and that death occurred at 1245 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) [illegible] Woodrow MD — ADDRESS R4 Box 212 Elkridge 27 Md — DATE SIGNED

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 17 1953 | Mt Olivet | Bal. County Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | LL | [illegible] | [illegible] |

Film #G-158 Item No.9 10/15/53 emp

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 S792

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY BALTIMORE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CATONSVILLE
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRING GROVE STATE HOSP.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN REISTERSTOWN
STREET ADDRESS (If rural give location) BERGMAN LANE.

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) JAMES (Last) KENNEDY

4. DATE OF DEATH: (Month) 9 (Day) 29 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WID.

8. DATE OF BIRTH: 6-19-1877

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): UNK.

10b. KIND OF BUSINESS OR INDUSTRY: UNKNOWN

11. BIRTHPLACE (State or foreign country): UNKNOWN

12. CITIZEN OF WHAT COUNTRY? UNK

13. FATHER'S NAME: UNK-

14. MOTHER'S MAIDEN NAME: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) UNK (If Yes, give war or dates of service) NO

16. SOCIAL SECURITY No.: 218-26-0590

17. INFORMANT & ADDRESS: RECORDS OF SPRING GROVE STATE HOSP.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) CARDIO-RESPIRATORY FAILURE — Interval Between Onset And Death: 5 MIN

Antecedent causes (b) DUE TO CEREBRAL THROMBOSIS — 4 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(c) DUE TO GENERALIZED CEREBRAL ARTEROSCLEROSIS — UNK.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/25, 1953, to 9-29, 1953, that I last saw the deceased alive on 9/29, 1953, and that death occurred at 8:30 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) W. O. McKinsey M.D. ADDRESS Spring Grove State Hosp. Catonsville Md. DATE SIGNED 9-29-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 10-1-53 — NAME OF CEMETERY OR CREMATORY St Thomas — LOCATION (City, town, or county) (State) Garrison Forest Md.

DATE REC'D BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Frank H. Meerdink — ADDRESS Catonsville Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

08793

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A-15

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arbutus; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible] Eldon Green

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arbutus; STREET ADDRESS (If rural, give location) 4800 Eldon Green

3. NAME OF DECEASED (Type or Print): (First) KATHRYN (Middle) S. (Last) KETTLER

4. DATE OF DEATH: (Month) (Day) (Year) September 14, 1953

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Oct. 4, 1908

9. AGE last birthday: 44 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Saleslady

10b. KIND OF BUSINESS OR INDUSTRY: Hutzler Bros. Co.

11. BIRTHPLACE (State or foreign country): Elmira, New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Aden Roberts

14. MOTHER'S MAIDEN NAME: Margaret --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Kenzie H. Kettler, Sr., 4800 Eldon Green

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | 2 hrs. |
| 420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) arteriosclerotic Heart Disease | 2 yrs |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec ....., 1951, to Sept. 14, 1953, that I last saw the deceased alive on Sept 14, 1951, and that death occurred at 1:40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

G Bradley Loughartby MD 1264 Francis Ave Halethorpe 27 Md 9-15-53

23. BURIAL, CREMATION, REMOVAL (Specify): burial | DATE THEREOF: 9/17/53 | NAME OF CEMETERY OR CREMATORY: Green Mount Cemetery | LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG. 9/16/53 | REGISTRAR'S SIGNATURE: A W Hudnit | 24. FUNERAL DIRECTOR ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Balto. |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Govdawn — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glenmont [illegible] |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 2512 Poplar Grove | STREET ADDRESS 2512 (If rural, give location) Poplar Grove |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) [illegible] | (Middle) [illegible] | (Last) [illegible] | 4. DATE OF DEATH | (Month) Sept. | (Day) 24 | (Year) 1953 |
| 5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH Aug 3 1895 | 9. AGE last birthday 58 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |

| | | | |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Trucker | 10b. KIND OF BUSINESS OR INDUSTRY Farming | 11. BIRTHPLACE (State or foreign country) Baltimore Co. Md. | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME [illegible] | | 14. MOTHER'S MAIDEN NAME [illegible] | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service) None | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs. Mary O. [illegible] 2512 Poplar Grove |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | Instant |
| Antecedent cause(s) 260 X | (b) Generalized arteriosclerosis | ? |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Diabetes Mellitus | 10 yrs. |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Bilateral Pulmonary Tbc Healed | 3 yrs. |

| | | | | |
|---|---|---|---|---|
| 19a. DATE OF OPERATION — | 19b. MAJOR FINDINGS OF OPERATION — | | | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — | (CITY OR TOWN) — | (COUNTY) — | (STATE) — |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. — | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? — | | |

22. I hereby certify that I attended the deceased from 1948, 19....., to 9-24-, 1953 that I last saw the deceased alive on 9-24-, 1953 and that death occurred at 1:15 p.m., from the causes and on the date stated above.

SIGNATURE Robert H. Oliver (Degree or title) M.D. ADDRESS 3105 N. Charles St. DATE SIGNED 9-25-53

| | | | | |
|---|---|---|---|---|
| 23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 9-28-53 | NAME OF CEMETERY OR CREMATORY Govdawn | LOCATION (City, town, or county) Govdawn | (State) |
| DATE REC'D BY LOCAL REG. [illegible] | REGISTRAR'S SIGNATURE [illegible] REG'D | 24. FUNERAL DIRECTOR [illegible] | ADDRESS [illegible] | |

VS. M5 (1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (19)53

# CERTIFICATE OF DEATH

Reg. Dist. No. 38

**1. PLACE OF DEATH:**
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Towson 4
LENGTH OF STAY (In this place): 35
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 8450 Oakleigh Road

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Towson 4
STREET ADDRESS (If rural give location): 8450 Oakleigh Road

**3. NAME OF DECEASED:** (Type or Print) (First) LAURA (Middle) KATHLEEN (Last) KLINEFELTER

**4. DATE OF DEATH:** (Month) Sept. (Day) 12, (Year) 19 53

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Married

**8. DATE OF BIRTH:** April 6, 1927

**9. AGE last birthday:** 26 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:** At Home

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** John Edward Osbourne

**14. MOTHER'S MAIDEN NAME:** Marie Schneemeyer

**15. WAS DECEASED EVER IN U.S ARMED FORCES?** (Yes, no, or unk.) No — (If Yes, give war or dates of service) None

**16. SOCIAL SECURITY No.:**

**17. INFORMANT & ADDRESS:** John Klinefelter, Towson 4, Md.

**18. MEDICAL CERTIFICATION**

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

744.0
Immediate cause (a) MYASTHENIA GRAVIS — Interval Between Onset And Death: 3 years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

**11. OTHER SIGNIFICANT CONDITIONS** Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☒ No ☐

**21.** ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-11-, 19 53 to 9-12-, 19 53, that I last saw the deceased alive on 9-11-, 19 53 and that death occurred at 5:30 A.M. 9-12-53, from the causes and on the date stated above.

SIGNATURE: Irma W. Jungerg (Degree or title) M.D. — ADDRESS: 809 Clearwood Rd — DATE SIGNED: 9-14-53

23. BURIAL, CREMATION, REMOVAL: (Specify) Cremation — DATE THEREOF: Sept. 15, 1953 — NAME OF CEMETERY OR CREMATORY: Greenmount Crematory — LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR: Sept. 15, 1953 — REGISTRAR'S SIGNATURE: Mabel C. Gray

24. FUNERAL DIRECTOR: John Burns' Sons, Towson, Md. — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WHITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 16 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY BALTO — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SPARROWS PT. (19) — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 245 S. MARINE AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY BALTO
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DUNDALK 22
STREET ADDRESS (If rural, give location) 245 ST. HELENA AVE

3. NAME OF DECEASED (Type or Print): (First) HELEN (Middle) BARBARA (Last) LAMKA
4. DATE OF DEATH: (Month) 9 (Day) 1 (Year) 1953
5. SEX: FEM
6. COLOR OR RACE: WH.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: F 4 8
9. AGE last birthday: (5) yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEWER
10b. KIND OF BUSINESS OR INDUSTRY: TIN MILL
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: [illegible]
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 213-07-57[illegible]
17. INFORMANT AND ADDRESS: [illegible] 2521 Bryden Ave - (19)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

15=X

Immediate cause (a) Generalized Carcinomatosis — 6 mos

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma Colon — 1 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 30, 1953, to Sept. 1, 1953, that I last saw the deceased alive on Sept 1, 1953, and that death occurred at 2.30A m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) MD — ADDRESS 5202 St. Pt. 19 — DATE SIGNED 9/2/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9-5-53 — NAME OF CEMETERY OR CREMATORY Holy Rosary — LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 5 '53 — REGISTRAR'S SIGNATURE Dawson L. Parker

24. FUNERAL DIRECTOR Albert Burke Brooks, Dundalk — ADDRESS

RECEIVED
[illegible] 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15.

**1. PLACE OF DEATH:**
COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort Howard
LENGTH OF STAY (in this place): 114 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Veterans Administration Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 3 Walkway Court

**3. NAME OF DECEASED:** (First) MELVIN (Middle) O. (Last) LANE

**4. DATE OF DEATH:** (Month) (Day) (Year) September 17 1953

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 9/6/21 | 32 yrs. | | |

| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Gas office | Baltimore, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Lane | Marie Bright |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| Yes | WW II | 213-16-5138 | Clin.Rec., Vet.Adm.Hosp., Ft.Howard, Md. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

410X

Immediate cause — (a) PULMONARY INFARCTION — Interval Between Onset And Death: 1 WK.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) RHEUMATIC HEART DISEASE WITH MITRAL STENOSIS — 3 YRS.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 26, 1953, to Sept. 17, 1953, ~~that I last saw the deceased~~ and that death occurred at 12:40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Robert C. Duvall — ADDRESS: VAH, FORT HOWARD, MD. — DATE SIGNED: 9/17/53

ROBERT C. DUVALL M.D.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9/21/53 — NAME OF CEMETERY OR CREMATORY: Baltimore National Cemetery — LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR: Sept. 21-53 — REGISTRAR'S SIGNATURE: Dawson L. Parker

24. FUNERAL DIRECTOR — ADDRESS: Lassahn Funeral Home, 7401 Belair Road, Baltimore, Md.

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Balto — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X — LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7301 Belair Rd X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X
STREET ADDRESS (If rural, give location) 7301 Belair Rd.

3. NAME OF DECEASED (Type or Print): (First) Elmer (Middle) F (Last) Lassahn

4. DATE OF DEATH: (Month) Sept (Day) 27 (Year) 1953

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married — 8. DATE OF BIRTH: Aug 6 1897 — 9. AGE last birthday: 56 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vice President-Printing — 10b. KIND OF BUSINESS OR INDUSTRY: Ascent Smith — 11. BIRTHPLACE (State or foreign country): Balto Co Md — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. Charles Lassahn — 14. MOTHER'S MAIDEN NAME: Lydia Wirsing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS: Mrs Elmer Lassahn 7301 Belair Rd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 6 weeks

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 2, 1949, to Sept 27, 1953, that I last saw the deceased alive on Sept 26, 1953, and that death occurred at 7:45 P m., from the causes and on the date stated above.

SIGNATURE: Edward Lewis — (Degree or title) M. D. — ADDRESS 6222 Belair Rd. Balto, Md — DATE SIGNED Sept 28, 1953

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 9/29/30 — NAME OF CEMETERY OR CREMATORY Moreland M. Cem — LOCATION (City, town, or county) (State): Balto Md

DATE REC'D BY LOCAL REG. Sept 29 1953 — REGISTRAR'S SIGNATURE Mrs M. D. Reynolds — 24. FUNERAL DIRECTOR — ADDRESS: Lassahn Funeral Home 7401 Belair Rd

RECEIVED
OCT 1 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15--

1. PLACE OF DEATH: COUNTY Balto. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7 Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown
STREET ADDRESS (If rural, give location) 7 Main St.

3. NAME OF DECEASED (Type or Print): (First) EVA (Middle) C. (Last) LEACH
4. DATE OF DEATH: (Month) Sept. (Day) 20 (Year) 1953
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Oct. 31, 1867
9. AGE last birthday: 85 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Walker
14. MOTHER'S MAIDEN NAME: Ethel Colter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT AND ADDRESS: Mrs. Evelyn L. Buppert-7 Main St., Reisters-town, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) BRONCHIAL PNEUMONIA | 48 HRS. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) CARCINOMA LEFT BREAST WITH PULMONARY METASTASES. | 2 YRS. |
| | (c) | |

170X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1950, to Sept. 20, 1953, that I last saw the deceased alive on Aug. 29 1953, and that death occurred at 7:40 A.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Martin E. Strobel | M.D. | Reisterstown Md. | 9/20/53 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/23/53 | Druid Ridge Cem. | Pikesville, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-21-53 | A.W. Hedrich, Asst. Registrar | Wm. J. Dickner & Sons | Balto. 17, Md. |

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A-104

1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middle River, Balto 20, Md. — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Trailer Camp, Off Eastern Blvd

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Hanley (Last) Lohr

4. DATE OF DEATH: (Month) Sept. (Day) 4 (Year) 53

5. SEX: male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: 5/24/27 | 9. AGE last birthday: 29 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricklayer | 10b. KIND OF BUSINESS OR INDUSTRY: Building | 11. BIRTHPLACE (State or foreign country): W Va. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Lohr | 14. MOTHER'S MAIDEN NAME: Daisey Brummyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII | 16. SOCIAL SECURITY NO.: 218-16-3543 | 17. INFORMANT AND ADDRESS: Helen Lohr 33 Masterson Drive

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — Minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF DEATH (Month) 9 (Day) 4 (Year) 1953 (Hour) 6 p.m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE J M Adamson M.D. (Degree or title) ADDRESS Deputy Medical Examiner Baltimore Co. Dundalk 22 Md DATE SIGNED 9/4/53

23. BURIAL, CREMATION, REMOVAL (Specify): Removal | DATE THEREOF 9-7-53 | NAME OF CEMETERY OR CREMATORY Ped House | LOCATION (City, town, or county) (State): Oakland Md.

DATE REC'D BY LOCAL REG. SEP 5 1953 | REGISTRAR'S SIGNATURE Edith Hurley mvl | 24. FUNERAL DIRECTOR J Brydenthie ADDRESS 1407 Eastern Ave

RECEIVED
SEP - 2 2003
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

(1554)

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lutherville
LENGTH OF STAY (in this place) abt 8 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS College Manor

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pikesville
STREET ADDRESS (If rural give location) 4110 Colonial Road

3. NAME OF DECEASED (Type or Print): (First) Josephine (Middle) La Mar (Last) Loveland
4. DATE OF DEATH: (Month) Sept (Day) 17 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct-6-1889
9. AGE last birthday: 63 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles W. LaMar
14. MOTHER'S MAIDEN NAME: Eleanor Armstrong
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT: Mrs. Lewis C. Loveland (Husband) Pikesville

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

153X Immediate cause (a) Carcinoma of colon — 2 yrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: metastases to rt. femur

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 22 Apr, 1953, to 17 Sept, 1953, that I last saw the deceased alive on 16 Sep, 1953, and that death occurred at 4:15 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Paul H Royer M.D. Pikesville 8 Md 17 Sep 53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Sept 19, 53
NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG. 9-18-53
REGISTRAR'S SIGNATURE A.W. Hedrich dmr.
24. FUNERAL DIRECTOR ADDRESS: Stewart & Mowen Co. 108 W. North Ave. Balto. #1.

VS. A15

Item 12 Film C158 9/23/53 mnb

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 ..12

# CERTIFICATE OF DEATH

Reg. Dist. No. 4...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

COUNTY: Baltimore — MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town): X Fort Howard

LENGTH OF STAY (in this place): 3 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Veterans Administration Hosp.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE: Maryland — COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 4

STREET ADDRESS (If rural give location): 1715 E. Baltimore Street

| 3. NAME OF DECEASED: (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) (Day) (Year) |
|---|---|---|---|
| IKE | (NMI) | LUBISKY | September 22 19 53 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 7/2/54 | 99 yrs. | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Baker & Cook | | Russia | US |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Moses Lubisky | Gittle (MN unknown) |

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| ✓ Yes SPA | Unknown | Clin.Records, Vet.Adm.Hosp., Ft.Howard, Md. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4211

Immediate cause (a) MYOCARDIAL INFARCTION — Interval Between Onset And Death: 14 hrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) ARTERIOSCIEROTIC CORONARY THROMBOSIS

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 0 | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I/WA attended the deceased from Sept. 19..,19.53., to Sept 22..., 1953., ~~that I last saw the deceased~~ and that death occurred at 1:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

FRANCIS G. DICKEY, M.D., CHIEF, MEDICAL SERVICE, VA HOSPITAL, FT. HOWARD, M.D 9/22/53

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-23-53 | Hebrew Rosedale Cemetery | Baltimore, Md. |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| 9-22-53 | A.W.Hedrich Asst. | Jack Lewis Funeral Home, 2100 Eutaw Place Balto., Md. |

VS-115 (1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 36

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information ■refully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

COUNTY Baltimore MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) 52 Catonsville

LENGTH OF STAY (in this place) 33yrs.1mo.10

HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE Maryland COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sparrows Point

STREET ADDRESS (If rural, give location)

| 3. NAME OF DECEASED: (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) (Day) (Year) |
|---|---|---|---|
| Florence | | Lynch | September 3, 1953 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 7-5-1885? | 68 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Pennsylvania | USA |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | Unknown | Records Spring Grove State Hospital |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 420.3 Immediate cause | (a) Cardiac failure | 6 days |
| DUE TO | | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) Arteriosclerotic heart disease | Years |
| DUE TO | | |
| | (c) Generalized arteriosclerosis | Years |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) M. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 8-29-, 1953, to 9-3-, 1953, that I last saw the deceased alive on 9-3-, 1953, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Ethel B. Hermann Grace MD Spring Grove State Hospital Catonsville 28, Maryland 9-3-53

| 23. BURIAL, CREMATION REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Sept. 4, 1953 | Zion Lutheran Cem. | Balto. Co., | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Sept 4 | T E Harry | Lansdale Funeral Home | 7401 Belair Rd. |
| 9-4-53 | | | |

VS-45

RECEIVED
FP 10 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

08804

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown
LENGTH OF STAY (in this place) 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 708 Main Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown
STREET ADDRESS (If rural, give location) 708 Main Street

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) Dolan (Last) Lyons

4. DATE OF DEATH (Month) Sept (Day) 23 (Year) 19 53

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH Dec 28 1862

9. AGE last birthday 90 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY -

11. BIRTHPLACE (State or foreign country) Ireland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Peter Dolan

14. MOTHER'S MAIDEN NAME Bridget Ivory

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS Bernard J Lyons Reisterstown Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 4 day

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Arteriosclerosis - General — 2 years
(c) Hypertension — 2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-30, 19..., to 9-23-53, 19..., that I last saw the deceased alive on 9-22-53, 19..., and that death occurred at 3 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jesse L Lafell M.D. Reisterstown Md 9-23-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Sept 26 1953 — NAME OF CEMETERY OR CREMATORY New Cathedral Cem. — LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REG. 9/24/53 — REGISTRAR'S SIGNATURE Mary D. Sline.

24. FUNERAL DIRECTOR Wm Berryman & Sons — ADDRESS Reisterstown Md

SEP 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 ..53

# CERTIFICATE OF DEATH

Reg. Dist. No. 33-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the names of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Near Hoffmanville
LENGTH OF STAY (in this place) 40 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Balti.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Millers, Md. Near Hoffmanvill
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Mazie (Middle) V. (Last) Marshall

4. DATE OF DEATH: (Month) Sept. (Day) 26, (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 30, 1882

9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph B. Holbrook

14. MOTHER'S MAIDEN NAME: Clarasia Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) XXXXXX (If Yes, give war or dates of service) XXXXXXXXXXXXXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S ADDRESS: Lawson V. Marshall Millers, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Angina Pectoris — Interval Between Onset And Death: 6 yrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Coronary Arteri-sclerosis — 6 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1947, to Sept. 24, 1953, that I last saw the deceased alive on Sept. 24, 1953, and that death occurred at 2:30 P.M. from the causes and on the date stated above.

SIGNATURE J. M. Porterfield (Degree or title) M.D. ADDRESS Hampstead DATE SIGNED 9/24/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Sept. 28, 1953

NAME OF CEMETERY OR CREMATORY St. Paul U.B.

LOCATION (City, town, or county) Millers, (State) MD.

DATE REC'D BY LOCAL REGISTRAR Sep 29 1953

REGISTRAR'S SIGNATURE Edwin S. Fridinger

24. FUNERAL DIRECTOR J. Jacob Hartenstein ADDRESS New Freedom, Pa.

VS. A15

RECEIVED
1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 37

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 6-1

**1. PLACE OF DEATH:**
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cockeysville Md
LENGTH OF STAY (in this place) 16 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Masonic Home

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 2033 N. Calvert St

**3. NAME OF DECEASED: (Type or Print)** (First) Maud (Middle) Marie (Last) McBurney

**4. DATE OF DEATH:** (Month) Sept. (Day) 2 (Year) 1953

**5. SEX:** F.

**6. COLOR OR RACE:** W.

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):**

**8. DATE OF BIRTH:** May 19 1872

**9. AGE last birthday:** 81 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Bus. Nurse

**10b. KIND OF BUSINESS/OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Boston Mass.

**12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME:** James Arthur Stewart

**14. MOTHER'S MAIDEN NAME:** Anna Fitzgerald

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:** None

**17. INFORMANT & ADDRESS:** Laura M. Schroeder

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause 422.1 (a) * Arterio sclerotic Cardiovascular Disease — Interval between onset and death: 2 yrs

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) * DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE (Specify)**

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1952, to Sept. 2, 1953, that I last saw the deceased alive on Sept. 2, 1953 and that death occurred at 10.50 a.m., from the causes and on the date stated above.

SIGNATURE Walter T. Lees (DEGREE OR TITLE) MD ADDRESS Cockeysville Md DATE SIGNED Sept 2/53

**23. BURIAL, ~~CREMATION~~ REMOVAL (Specify):** DATE THEREOF 9/5/53 NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REG. 9/2/53 REGISTRAR'S SIGNATURE Laura M. Schroeder

**24. FUNERAL DIRECTOR** Wm. Cooke, St Paul & Preston ADDRESS

RECEIVED
SEP 4 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]7

# CERTIFICATE OF DEATH

Reg. Dist. No. .. ....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Pikesville
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 100 Old Court Rd.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Pikesville
STREET ADDRESS (If rural give location): 100 Old Court Rd.

**3. NAME OF DECEASED:** (Type or Print) (First) Ida Mae (Middle) (Last) McKenna

**4. DATE OF DEATH:** (Month) Sept. (Day) 24 (Year) 19 53

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED,** (Specify): Seperated

**8. DATE OF BIRTH:** May 8, 1901

**9. AGE** Last birthday: 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:** None

**11. BIRTHPLACE** (State or foreign country): Carroll Co. Maryland

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Edward M. Zile

**14. MOTHER'S MAIDEN NAME:** Emma Susan Wages

**15 WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:** None

**17. INFORMANT & ADDRESS:** Grace Marie Ruppel, 100 Old Court Rd

**18. MEDICAL CERTIFICATION**

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X
Immediate cause (a) CARCINOMA DESCENDING COLON — Interval Between Onset And Death: ONE YEAR

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) & METASTASES TO LIVER &
DUE TO (c) LUNGS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** 4/5/52 - 4/24/53

**19b. MAJOR FINDINGS OF OPERATION:** CARCINOMA DESCENDING COLON

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

**PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

**TIME OF INJURY** (Month) (Day) (Year) (Hour) m.

**INJURY OCCURED** While at Work ☐ Not While At Work ☐

**HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from 4/1, 19 52, to 9/24, 19 53, that I last saw the deceased alive on 9/23, 19 53, and that death occurred at 10 P.M. 9/24/53, from the causes and on the date stated above.

SIGNATURE (Degree or title): Calvin A. Hines M.D. — ADDRESS: 301 Med. Arts Bldg — DATE SIGNED: 9/25/53

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE THEREOF: 9-26-53 — NAME OF CEMETERY OR CREMATORY: Druid Ridge — LOCATION (City, town, or county) (State): Pikesville, Md

DATE REC'D BY LOCAL REGISTRAR: 9-25-53 — REGISTRAR'S SIGNATURE: A.W.Hedrich dmr.

**24. FUNERAL DIRECTOR** — ADDRESS: Frank H. Newell Inc. Pikesville, Md

(2)

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 2 12

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

(1)

VS. A15

1. PLACE OF DEATH: Catonsville.
COUNTY Baltimore MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
LENGTH OF STAY (in this place) 6 Weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wayne Nursing Home, 98 Smithwood Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Balto.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 611 Woodington Rd.

3. NAME OF DECEASED: (Type or Print) (First) Rosa (Middle) E. (Last) Mehrling

4. DATE OF DEATH: (Month) Sept. (Day) 13 (Year) 19 53

5. SEX: F.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: March 16, 1873

9. AGE last birthday: 80 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): H.W.

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert Bray

14. MOTHER'S MAIDEN NAME: Emma Hughlett

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Edward A. Mehrling, 611 Woodington Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

443X
Immediate cause (a) Cerebral vascular accident probably hemorrhage
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertensive arteriosclerotic cardio-vascular
DUE TO disease
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 21, 19 44, to Sept. 13, 19 53, that I last saw the deceased alive on Sept. 13 19 53 and that death occurred at 12:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
4116 Edmondson Avenue Sept. 14, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 16/53
NAME OF CEMETERY OR CREMATORY Woodlawn
LOCATION (City, town, or county) (State) Woodlawn Md.

DATE REC'D BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Harry H. Lintzenich ADDRESS 4101 Edmondson Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 37

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Baltimore; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Lutherville; MARYLAND LENGTH OF STAY (in this place) 3 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS College Manor

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Balto; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore X; STREET ADDRESS (If rural give location) 6027 Belona Balto 12

3. NAME OF DECEASED: (Type or Print) (First) Henry (Middle) Edgar (Last) Miles

4. DATE OF DEATH: (Month) (Day) (Year) September 8 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: March 30 1864

9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: cabinet maker

10b. KIND OF BUSINESS OR INDUSTRY: own business

11. BIRTHPLACE (State or foreign country): Baltimore Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John B. Miles

14. MOTHER'S MAIDEN NAME: Martha Marks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Chas B. Chilcoat, Sparks, Md.

18. MEDICAL CERTIFICATION

| | | Interval Between Onset And Death |
|---|---|---|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| 332.X Immediate cause | (a) Cerebral Thrombosis | 9 hrs. |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) DUE TO Generalized arteriosclerosis | years. |
| 260.X) | (c) DUE TO | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Diabetes mellitus | 3 years |

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 2, 1953, to Sept. 8, 1953, that I last saw the deceased alive on Sept 8, 1953, and that death occurred at 7:30 p.m; from the causes and on the date stated above.

SIGNATURE (Degree or title) Elizabeth B. Shirill M.D. ADDRESS Cockeysville, Md. DATE SIGNED 9-15-53.

23. BURIAL, CREMATION, REMOVAL (Specify) Buried DATE THEREOF 9-11-53 NAME OF CEMETERY OR CREMATORY Jessops Methodist LOCATION (City, town, or county) (State) Sparks, Md.

DATE REC'D BY LOCAL REGISTRAR 10 Sept 1953 REGISTRAR'S SIGNATURE Anne Armistead MacRae

24. FUNERAL DIRECTOR ADDRESS L. Scott Brooks, Sparks, Md.

VS: A15 T

RECEIVED
SEP 11 1963
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The ... especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Baltimore; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville; LENGTH OF STAY (In this place) 4 mos. 10 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore; STREET ADDRESS (If rural, give location) 1802 Eutaw Place

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) (Last) Miller

4. DATE OF DEATH: (Month) September (Day) 24 (Year) 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Oct 15-1889 Unknown

9. AGE last birthday: 63 yrs. If under 1 year: Months, Days; If under 24 hours: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT AND ADDRESS: Records Spring Grove State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

902.7 Immediate cause (a) Acute Cardiac failure

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic arteriosclerotic heart disease

(c) Fracture of the right femur--accident

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH | PLACE (Home, farm, factory, street, office bldg., etc.) Hospital | (CITY OR TOWN) Catonsville | (COUNTY) Balto | (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 17 53 m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Possible fell out of bed

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jos. M. Kieffer M.D. Resident Pathologist 1010 Leadenhall Sept 24 53

INTERMENT, CREMATION | DATE THEREOF: Sept 27 1953 | NAME OF CEMETERY OR CREMATORY: Mt Olive | LOCATION (City, town, or county): Easton | (State): Md

DATE RECD BY LOCAL REG.: Sept 26 1953 | REGISTRAR'S SIGNATURE: R.W. | 24. FUNERAL DIRECTOR | ADDRESS: Wm Lloyd Fine - 121 E Dover St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 8-51

**1. PLACE OF DEATH:**
COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Catonsville
LENGTH OF STAY (in this place): 7yr.5mo.17days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Spring Grove State Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location): 2245 Kirk Avenue

| 3. NAME OF DECEASED: (First) (Middle) (Last) | 4. DATE OF DEATH: (Month) (Day) (Year) | 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|---|---|
| Frank Miller | September 8, 1953 | Male | White | Widowed | 4-3-1893 | 60 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laundry | | Maryland | USA |

**13. FATHER'S NAME:** Benjamin Miller

**14. MOTHER'S MAIDEN NAME:** Mary McQue

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | 215-03-7946 | Mrs. Verna Nicholson--Dau-2245 Kirk Avenue Baltimore, Maryland |

**18. MEDICAL CERTIFICATION:**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| 420.0 Immediate cause | (a) Cardiac failure and pulmonary oedema | 2 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) DUE TO: Arteriosclerotic heart disease | Years |
| | (c) DUE TO: Generalized arteriosclerosis | Years |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Post traumatic brain syndrome — 7½ years

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? |
|---|---|---|
| 3-18-46 | Bilateral trephines-rt. subtemporal decompression (Operation at John Hopkins Hospital for relief of intracranial pressure | Yes ☒ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (STATE) |
|---|---|---|
| | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| M. | | |

22. I hereby certify that I attended the deceased from 9-8, 19 53, to 9-8, 19 53, that I last saw the deceased alive on 9-8, 19 53, and that death occurred at 5:35 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE): Ethel B. Herrmann-Green M.D. — ADDRESS: Spring Grove State Hospital Catonsville 28, Maryland — DATE SIGNED: 9-8-53

| 23. BURIAL, CREMATION REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 9/11/53 | St. Peters Cemetery | Baltimore, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 10 1953 | | Wm. Cook Inc., | 1217 St. Paul Street |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

COUNTY Baltimore — MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) 52 Catonsville

LENGTH OF STAY (in this place) 1 mo. 0 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE Maryland COUNTY Baltimore County

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Randallstown X

STREET ADDRESS (If rural, give location) Old Court Road

| 3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) | 4. DATE OF DEATH: (Month) (Day) (Year) |
|---|---|
| Marsden Miller | September 3, 1953 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | 5-19-1887 | 66 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer? | | New York | USA |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Frederick Miller | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| Unknown | Unknown | Records Spring Grove State Hospital |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| 420.0 Immediate cause | (a) Cardio-respiratory failure | 1 week |
| DUE TO | | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) Arteriosclerotic heart disease and | Years |
| ~~DUE TO~~ | (c) Unresolved pneumonia | 1 month |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| M. | | |

22. I hereby certify that I attended the deceased from 7-31-53, to 9-3-53, that I last saw the deceased alive on 9-3-53, and that death occurred at 2:58 p.m., from the causes and on the date stated above.

| SIGNATURE (DEGREE OR TITLE) | ADDRESS | DATE SIGNED |
|---|---|---|
| Ethel B. Hermann-Green MD | Spring Grove State Hospital Catonsville 28, Maryland | 9-3-53 |

| 23. BURIAL, CREMATION REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 8/53 | New Cathedral | Old Frederick Rd |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR: ADDRESS |
|---|---|---|
| 9/16/53 | V E. Harry | Harry H Waltke 4101 Edmondson ave |

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

05813

Reg. Dist. No. 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Baltimore; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Fort Howard
LENGTH OF STAY (in this place): 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 42 Parole Street

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) (Last) MOONEY
4. DATE OF DEATH: (Month) September (Day) 9 (Year) 1953

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | 5-20-23 | 30 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Naval Academy
11. BIRTHPLACE (State or foreign country): Annapolis, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph Mooney
14. MOTHER'S MAIDEN NAME: Annie Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT AND ADDRESS: Clin.Rec., Vet.Adm.Hosp., Ft.Howard, Md.

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) ACUTE MASSIVE NECROSIS OF LIVER | 2 WEEKS |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) DETERMINATION OF CAUSE AWAITING TOXICOLOGICAL EXAMINATION (Had been drinking a few days before developing | |
| | (c) jaundice. Presumed he drank some toxic compound - no evidence | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: to indicate that it was chlorinated hydrocarbon)

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): 9 - 9 - 53 m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* X, *Inspection* , *Inquiry* *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* , *accident* X, *suicide* , *homicide* , *undetermined* .

SIGNATURE (Degree or title): M Marmont M.D | ADDRESS: Deputy Medical Examiner Balto. Co. Randallstown Md | DATE SIGNED: 9/9/53

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/12/1953 | National Cemetery | West St. Annapolis, Md |

DATE REC'D BY LOCAL REG.: Sept. 10, 1953. | REGISTRAR'S SIGNATURE: Dawson L. Fuller | 24. FUNERAL DIRECTOR: Ethel Hicks Funeral Home, Annapolis, Md. | ADDRESS: 45 Northwest Street

mnt.

SEP 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 118614

# CERTIFICATE OF DEATH

Reg. Dist. No. 33

**1. PLACE OF DEATH:**
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Upperco Rural
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hereford Rd.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Upperco Rural X
STREET ADDRESS (If rural, give location) Hereford Rd

**3. NAME OF DECEASED: (Type or Print)** (First) Louisiana (Middle) (Last) Morfoot

**4. DATE OF DEATH:** (Month) September (Day) 10 (Year) 19 53

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | January 8, 1870 | 83 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Maryland | U.S.A. |

**13. FATHER'S NAME:** George Hale

**14. MOTHER'S MAIDEN NAME:** Sarah Marsh

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)** (If Yes, give war or dates of service) No

**16. SOCIAL SECURITY NO.:** —

**17. INFORMANT & ADDRESS:** Mrs Melva Thompson, Upperco Md

**18. MEDICAL CERTIFICATION**

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:**

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Uremia Myocarditis | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | DUE TO (b) Arteriosclerotic Cardio Vascular Lesions | ? |
| | DUE TO (c) | |

**II. OTHER SIGNIFICANT CONDITIONS:** Conditions contributing to the death but not related to the disease or condition causing death. —

**19a. DATE OF OPERATION:** —

**19b. MAJOR FINDINGS OF OPERATION:** —

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) M. —

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Aug 27, 19 53, to Sept 10, 19 53, that I last saw the deceased alive on Sept 9, 19 53, and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Joseph E Bond M.D. Hampstead Md Sept 10, 1953

| 23. BURIAL, CREMATION / REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 11 53 | Houston | Balto Co Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-10-53 | Mary B. Shue | Edw C Tipton | Hampstead Md |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

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SEP 14
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Fort Howard
LENGTH OF STAY (in this place) 8hrs 45min
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Do
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge,
STREET ADDRESS (If rural give location) 607 Race Street

3. NAME OF DECEASED: (Type or Print) (First) NORMAN (Middle) W. (Last) MORGAN

4. DATE OF DEATH: (Month) September (Day) 3 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 10-4-19

9. AGE last birthday: 33 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Ice man

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cambridge, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Dewey Morgan

14. MOTHER'S MAIDEN NAME: Alverta Thomas

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW II

16. SOCIAL SECURITY No.: 220-03-2834

17. INFORMANT & ADDRESS: Clin.Rec., Vet.Adm.Hosp., Ft.Howard, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0

Immediate cause (a) CIRRHOSIS OF LIVER — Interval Between Onset And Death: UNKNOWN

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sep. 2 19 53, to Sep. 3 19 53, that I last saw the deceased 4:30 P.M. and that death occurred at 1:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) WILLIAM B. VANDEGRIFT, M. D.

ADDRESS VAH, FORT HOWARD, MD.

DATE SIGNED 9-3-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 9-5-53

NAME OF CEMETERY OR CREMATORY Dorchester Cemetery

LOCATION (City, town, or county) (State) Cambridge, Maryland

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS Granville Lecompte, Cambridge, Maryland

VS. 415

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: BALTIMORE — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: TOWSON
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1312 WESTELLEN RD

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: BALTO.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: DUNDALK
STREET ADDRESS (If rural, give location): 34 BROADSHIP

3. NAME OF DECEASED (Type or Print): (First) ETHEL (Middle) (Last) MORRIS

4. DATE OF DEATH: (Month) SEPTEMBER (Day) 3 (Year) 1953

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: OCT 2 1885

9. AGE last birthday: 67 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BRADDOCK PA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOBIAS MC DONOUGH

14. MOTHER'S MAIDEN NAME: ANNE MC DONOUGH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: JOHN F. MORRIS 34 BROADSHIP

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| 153X Immediate cause | (a) GENERALIZED CARCINOMATOSIS | 9 MONTHS |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) CARCINOMA OF COLON | 2 YEARS |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 8:15 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Donald L. Somerville, Md. — ADDRESS: 25 W Pa. Ave Towson 4, Md — DATE SIGNED: Sept 3, 1953

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE THEREOF: SEPT 5, 1953 — NAME OF CEMETERY OR CREMATORY: MORELAND PARK — LOCATION (City, town, or county) (State): PARKVILLE MD

DATE REC'D BY LOCAL REG.: Sept. 8, 1953 — REGISTRAR'S SIGNATURE: Raoul C. May

24. FUNERAL DIRECTOR — ADDRESS: ULLRICH FUNERAL HOME 212 DUNDALK

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EAU V. S.

MARBIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Baltimore |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville — LENGTH OF STAY (in this place) 5? | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 13 A Seminole Ave. | STREET ADDRESS (If rural, give location) 13 A Seminole Ave. |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| ANN | ELIZABETH | NEILY | Sept. | 13 | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | widowed | Nov. 1, 1868 | 84 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at home | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel Grape | Emma Jane Malone |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | none | Mrs. Carl M. Hofmann-13 A Seminole Ave. |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| 420.1 Immediate cause (a) Myocardial Infarction | 10d. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chr. Hypertensive Cardio-Vascular Disease | 15 yrs. |
| (c) | |

| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |
|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION |

20. AUTOPSY? Yes ☐ No ☒

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 9-3, 1942, to 9-14, 1953, that I last saw the deceased alive on 9-14, 1953, and that death occurred at 4:00 P. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Wilmus K. Gallagher | M.D. | Catonsville 28, Md. | 9-15-53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/17/53 | Greenmount Cem. | Balto., Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR. | ADDRESS |
|---|---|---|---|
| 9/15/53 | A. W. Hunt Jr | Wm. J. Tickner & Sons | Balto. 17, Md. |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pikesville
LENGTH OF STAY (in this place) 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7105 Campfield Rd

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pikesville
STREET ADDRESS (If rural give location) 7105 Campfield Rd.

**3. NAME OF DECEASED:** (Type or Print) (First) Roland (Middle) Arthur (Last) Novak

**4. DATE OF DEATH:** (Month) Sep (Day) 4 (Year) 1953

**5. SEX:** M

**6. COLOR OR RACE:** W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** married

**8. DATE OF BIRTH:** 29 July 1897

**9. AGE last birthday:** 56 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired): Pr[illegible]t

**10b. KIND OF BUSINESS OR INDUSTRY:** Linotype Composition

**11. BIRTHPLACE (State or foreign country):** Maryland

**12. CITIZEN OF WHAT COUNTRY?** United States

**13. FATHER'S NAME:** John novak

**14. MOTHER'S MAIDEN NAME:** Annie Herrmann

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) yes (If Yes, give war or dates of service) World War I

**16. SOCIAL SECURITY NO.:** 215-32-1619

**17. INFORMANT & ADDRESS:** Mrs Roland Novak, 7105 Campfield, Baltimore 7

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between *Onset And Death

181X
Immediate cause (a) ..... Carcinoma of bladder

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) .....

DUE TO (c) Cerebral vascular accident — 2 hrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** June 1952

**19b. MAJOR FINDINGS OF OPERATION** Carcinoma of bladder

**20. AUTOPSY?** Yes ☐ No ☒

**21.** ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1951, to 4 Sep., 1953, that I last saw the deceased alive on 2 Sep., 1953, and that death occurred at 4 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Paul H Rayne M D
ADDRESS Pikesville 8 Md
DATE SIGNED 4 Sep 53

**23.** BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9/7/53
NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.
LOCATION (City, town, or county) (State) Balto. Co., Md.

DATE REC'D BY LOCAL REGISTRAR September 5. 1953
REGISTRAR'S SIGNATURE R.W.

**24.** FUNERAL DIRECTOR Wm. J. Vickner & Sons
ADDRESS Balto. 17, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 33

1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown | LENGTH OF STAY (in this place) 1 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Silver Cross Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oakland
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Beulah (Middle) Elizabeth (Last) Orr
4. DATE OF DEATH: (Month) (Day) (Year) Sept. 12, 1953
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single
8. DATE OF BIRTH: Feb. 15, 1912
9. AGE last birthday: 41 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inmate at home
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Narrows, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John M. Orr
14. MOTHER'S MAIDEN NAME: Ella Blanche Orr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Mrs. Fisher, Church St. Keyser, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Epilepsy — 39 yrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: none

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH: no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (Silver Cross) (CITY OR TOWN) Reisterstown, (COUNTY) Balto., (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) 9-12-53 9:30 P.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? while watching T.V. had an epileptiform seizure & expired

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
D. D. Caples Deputy Med. Exam. M.D. Reisterstown, Maryland 9-17-53

DISPOSITION (Burial, Cremation, Removal) Burial
DATE THEREOF Sept. 15, 1953
NAME OF CEMETERY OR CREMATORY Queenspoint Cem
LOCATION (City, town, or county) (State) Mineral Co. W. Virginia

DATE RECEIVED BY LOCAL REGISTRAR 9-17-53
REGISTRAR'S SIGNATURE Mary B. Eline
24. FUNERAL DIRECTOR ADDRESS J.F. Eline & Sons, Reisterstown, Md.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 1 1 1913
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

# CERTIFICATE OF DEATH

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: Fort Howard
LENGTH OF STAY (in this place): 42 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
STREET ADDRESS (If rural give location): 87 West Main Street

3. NAME OF DECEASED: (First) GEORGE (Middle) (NMI) (Last) OSBORNE
4. DATE OF DEATH: (Month) SEPTEMBER (Day) 2 (Year) 19 53
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 1-30-77
9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Movie owner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cadiz, Ohio
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Charles Osborne
14. MOTHER'S MAIDEN NAME: Martha Ritchie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes — (If Yes, give war or dates of service): 3-10-99 to 4-8-02
16. SOCIAL SECURITY NO.: 217-09-6450
17. INFORMANT & ADDRESS: Clin.Rec.,Vet.Adm.Hosp.,Ft.Howard,Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) CARCINOMA OF RIGHT LUNG — DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) — DUE TO — (c)

Interval Between Onset And Death: 5 MONTHS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22, 19 53 to Sep. 2, 19 53, [illegible] and that death occurred at 6:14 P.M., from the causes and on the date stated above.
SIGNATURE (Degree or title): WILLIAM B. VANDEGRIFT, M. D.
ADDRESS: VAH, FORT HOWARD, MARYLAND
DATE SIGNED: 9-3-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 9-7-53
NAME OF CEMETERY OR CREMATORY: New Oxford Cemetery
LOCATION (City, town, or county) (State): New Oxford, Pennsylvania

DATE REC'D BY LOCAL REGISTRAR: 9-3-53
REGISTRAR'S SIGNATURE: Mary B. Sline
24. FUNERAL DIRECTOR: J. E. Myers, Jr. Funeral Home
ADDRESS: 33 Willis Street, Westminster, Maryland

RECEIVED

BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 62

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A-154

1. PLACE OF DEATH:
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort Howard
LENGTH OF STAY (in this place): 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Talbot
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Easton
STREET ADDRESS (If rural give location): 54 S. Washington Street

3. NAME OF DECEASED: (First) THOMAS (Middle) G. (Last) PARKS
4. DATE OF DEATH: (Month) September (Day) 5 (Year) 19 53

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 8-17-06 | 47 yrs. | | | | |

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Motor Company
11. BIRTHPLACE (State or foreign country): Denton, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Parks-
14. MOTHER'S MAIDEN NAME: Saddie Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW II
16. SOCIAL SECURITY No.: 218-09-7302
17. INFORMANT & ADDRESS: Clim.Rec., Vet.Adm.Hosp., Ft.Howard, Md.

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | Interval Between Onset And Death |
|---|---|---|
| 4211 Immediate cause | (a) CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION | UNKNOWN |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH OLD ANTERIOR MYOCARDIAL INFARCTION | 5 YEARS |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 19 53, to Sept. 5, 19 53, [illegible] and that death occurred at 8:15 P.M., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| DAVID W. PARKE, M. D. David W. Parke | | VAH, FORT HOWARD, MARYLAND | 9-6-53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 8/53 | Denton Cemetery | Denton, Maryland |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| 9/8/53 | John O George<br>Dawson O. Barber | Virgil Moore Funeral Home, Denton, Maryland |

RECEIVED
SEP 11 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 2

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. .....

**1. PLACE OF DEATH:**
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pikesville
LENGTH OF STAY (in this place) Worked-5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Milford Mill Road

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland COUNTY Balto. City
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore -16 00-01
STREET ADDRESS (If rural, give location) 1607 Longwood Street

**3. NAME OF DECEASED:** (Type or Print) (First) Wilbert (Middle) Harrison (Last) Pearce

**4. DATE OF DEATH** (Month) Sept. (Day) 1 (Year) 1953

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Oct. 11, 1888 | 64 yrs. | | | | |

**10a. USUAL OCCUPATION** (Give kind of work done during most of work life, even if retired): Chauffuer
**10b. KIND OF BUSINESS OR INDUSTRY:** D. Hillman & Co. Road Construction
**11. BIRTHPLACE** (State or foreign country): Balto. Co., Md.
**12. CITIZEN OF WHAT COUNTRY?** U. S. A.

**13. FATHER'S NAME:** John M. Pearce
**14. MOTHER'S MAIDEN NAME:** Elizabeth DeVese

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) (If Yes, give war or dates of service): No
**16. SOCIAL SECURITY No.:** 220-01-0327
**17. INFORMANT & ADDRESS:** Mrs. Louisa Pearce (Wife) 3928 Flowerton Road

**18. MEDICAL CERTIFICATION**

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:** (Interval Between Onset and Death)

4351

Immediate cause (a) Coronary Artery Disease — 1 yr.
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Hypertensive C.V. Disease — 7 yrs.
DUE TO
(c)

**II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH:** none

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? |
|---|---|---|
| none | none | Yes ☐ No ☒ |

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. ---
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY none
21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR? not an injury

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE D. D. Taylor M. D. — Deputy Med. Exam.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED 9-3-'53

| 23. BURIAL, CREMATION, REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 5-53 | New Cathedral | Balto. Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9/3/53 | A. W. Hedrick M.D. | Harry Hintze, | 4101 Edmondson Ave |

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 53-22-11

# CERTIFICATE OF DEATH

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Owings Mills
LENGTH OF STAY (in this place) 3 mos. 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood State Tr. School

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 1353 Broening Highway

**3. NAME OF DECEASED:** (Type or Print) (First) Alphonse (Middle) (Last) Pisani

**4. DATE OF DEATH:** (Month) Sept (Day) 8 (Year) 1953

**5. SEX:** M.

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Single

**8. DATE OF BIRTH:** 10-6-44

**9. AGE last birthday:** 8 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): None

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country) Maryland

**12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME:** Alphonse Joseph Pisani

**14. MOTHER'S MAIDEN NAME:** Veronica Grobowski

**15 WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY No.:**

**17. INFORMANT & ADDRESS:** Hospital Records

**18. MEDICAL CERTIFICATION**

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

491X
Immediate cause (a) Bilateral Broncho-pneumonia — 13 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Spastic Quadriplegia — Since birth
DUE TO (c) Marked Hydrocephalus — Since birth

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☑

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 28, 1953, to Sept 8, 1953, that I last saw the deceased alive on Sept 8, 1953, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Viola B. Johns M.D Rosewood Owings Mills, Md 9-8-53

**23. BURIAL, CREMATION, REMOVAL** (Specify) BURIAL
DATE THEREOF SEPT. 10/53
NAME OF CEMETERY OR CREMATORY ST. STANISLAUS
LOCATION (City, town, or county) (State) DUNDALK AVE. BALTO. MD.

DATE REC'D BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE Mary Eline mmb
**24. FUNERAL DIRECTOR** Frank Kirchner ADDRESS 322 [illegible]

RECEIVED
SEP 15 19
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ■■ is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Towson
LENGTH OF STAY (in this place): 55
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Towson Nursing Home

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 508 E. North Avenue

**3. NAME OF DECEASED:** (Type or Print) (First) BELLE (Middle) BEVIS (Last) POTTER

**4. DATE OF DEATH:** (Month) September (Day) 8, (Year) 1953

**5. SEX:** female

**6. COLOR OR RACE:** white

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Widowed

**8. DATE OF BIRTH:** Jan. 12, 1869

**9. AGE last birthday:** 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): housewife

**10b. KIND OF BUSINESS OR INDUSTRY:** own home

**11. BIRTHPLACE** (State or foreign country): Milford, Ohio

**12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME:** Uriel Bevis

**14. MOTHER'S MAIDEN NAME:** Anna Belle Ogden

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Annabelle Potter, 5610 Woodmont Avenue, Apt. B

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause — (a) Cardiac Failure — Interval Between Onset and Death: 8 1/2 hrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Arteria-Sclerotic C-V disease — Interval Between Onset and Death: 4 yrs.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/18, 1949 to 9/8, 1953 that I last saw the deceased alive on 9/7, 1953 and that death occurred at 5:45 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Jno. F. Sedlack M.D. — 200 W. Pennsa. Ave Towson. — 9/8/53

**23. BURIAL, CREMATION REMOVAL (Specify):** removal — DATE THEREOF: 9/10/53 — NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery — LOCATION (City, town, or county) (State): Hamilton, Ohio

DATE REC'D BY LOCAL REG. 9-9-53 — REGISTRAR'S SIGNATURE: A.W. Hedrich dmr. — **24. FUNERAL DIRECTOR** — ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street

VS. A15 7

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lansdowne, Md. — LENGTH OF STAY (in this place) 8 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 612 Washington Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lansdowne, Md.
STREET ADDRESS (If rural give location) 612 Washington Avenue

3. NAME OF DECEASED (Type or Print): (First) Corinne (Middle) W. (Last) Radcliffe
4. DATE OF DEATH: (Month) Sept. (Day) 28, (Year) 1953
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED: Widowed
8. DATE OF BIRTH: Nov. 13, 1881
9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Charles Edward Willey
14. MOTHER'S MAIDEN NAME: Martha Francis Burns
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. [redacted] Radcliffe

18. MEDICAL CERTIFICATION Charles

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443x Immediate cause (a) Acute congestive heart failure — 1 hr.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive arteriosclerotic cardiovascular disease — yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1953, to Sept. 28, 1953, that I last saw the deceased alive on Sept. 28, 1953, and that death occurred at 7 A.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Herbert A. Lucikas, M.D. 2436 Washington Blvd. Sept 28 1953

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 9/30/53 | NAME OF CEMETERY OR CREMATORY Olivet | LOCATION (City, town, or county) St. Michaels, Md (State)

DATE REC'D BY LOCAL REG. 9/30/53 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR Norman V. Marshall ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 6 1933
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the figures of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Baltimore; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown; LENGTH OF STAY (In this place) 8 mos.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 461 S. Main Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; ~~COUNTY~~ City Balto.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) 124 W. 25th Street

3. NAME OF DECEASED (Type or Print): (First) Rosa (Middle) May (Last) Redman

4. DATE OF DEATH: (Month) Sept. (Day) 16 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 7, 1891

9. AGE last birthday: 62 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Stabler

14. MOTHER'S MAIDEN NAME: Mary E. Kelley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Bessie Watson (sister) 461 S. Main St., Reisterstown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420 1 Immediate cause (a) Infarction, coronary — Interval between onset and death: 40 hrs.

Antecedent cause(s) Angina Pectoris — 7 mos.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Arteriosclerotic C.-V. disease — 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none (CITY OR TOWN) ---- (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): not an injury.

INJURY OCCURRED While at Work ☐ Not While At work ☐ ---

HOW DID INJURY OCCUR? not an injury

22. I hereby certify that I attended the deceased from 2-2-, 1953, to 9-16, 1953, that I last saw the deceased alive on 9-15-, 1953, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE D. D. Caples (Degree or title) M.D. ADDRESS 6 Hanover Road, Reisterstown, Md. DATE SIGNED 9-16-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE Sept 19/53 NAME OF CEMETERY OR CREMATORY Woodlawn LOCATION (City, town, or county) (State) Woodlawn, Md

DATE REC'D BY LOCAL REG. SEP 18 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Austin E. Donovan ADDRESS 3818 Roland Ave

VS. A15

ITEM 8: film 9-21-53

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: Catonsville
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Spring Grove State Hosp

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md COUNTY Prince Georges
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Suitland Wash 20, DC RFD 2
STREET ADDRESS (If rural, give location): 3127 Parkway Terrace Drive

**3. NAME OF DECEASED: (Type or Print)** (First) Arthur (Middle) B (Last) Richardson

**4. DATE OF DEATH:** (Month) Sept (Day) 1 (Year) 1953

**5. SEX:** male

**6. COLOR OR RACE:** white

**7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):** married

**8. DATE OF BIRTH:** Oct 8, 1882

**9. AGE last birthday:** 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):** Insurance Sales

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE (State or foreign country):** Maryland

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Thaddeus Richardson

**14. MOTHER'S MAIDEN NAME:** Alice Richardson

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)** no
(If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Mrs Mamie Richardson 3127 Parkway Terrace Drive

**18. MEDICAL CERTIFICATION**

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:** 420.1

Immediate cause (a) Coronary (Mocardial infarction) — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) generalized Arteriosclerosis — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: (a) ; (b) Yrs

**II. OTHER SIGNIFICANT CONDITIONS:** Conditions contributing to the death but not related to the disease or condition causing death. Decubit - left hip & sacral

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☑

**21. ACCIDENT / SUICIDE / HOMICIDE (Specify)**

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 19 52, to Sept 1, 19 53, that I last saw the deceased alive on Sept 1, 1953, and that death occurred at 3 A.M. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Arthur M Henson M.D — Spring Grove State Hosp — 9/1/53

**23. BURIAL, CREMATION REMOVAL (Specify):** Burial

DATE THEREOF: Sept 3-1953

NAME OF CEMETERY OR CREMATORY: Cedar Hill

LOCATION (City, town, or county) (State): Suitland Md

DATE REC'D BY LOCAL REG. Sept 1st-53

REGISTRAR'S SIGNATURE: T E Hunter

**24. FUNERAL DIRECTOR** ADDRESS: Sessums Bro. - 2007 Nichols Ave S.E. Washington, DC

VS. A15

RECEIVED
SEP 3 . .
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0882

# CERTIFICATE OF DEATH

Reg. Dist. No. ..

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important.

VS. 4

1. NAME OF DECEASED (Type or Print): MARY J. RIGBY

2. DATE OF DEATH: Sept. 14, 1953

3. PLACE OF DEATH: A. Baltimore City, County: Towson

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Armacost Nursing Home

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 5013 Harford Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | white | widowed | Mar. 20, 1856 | 97 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Frank Wachter, ADDRESS: 5013 Harford Road.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: -

19B. MAJOR FINDINGS OF OPERATION: -

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22. *I hereby certify that I attended the deceased from* May 19 53 *to* Sept 14 19 53 *that I last saw the deceased alive on* Sept 10 19 53 *and that death occurred at* 3:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Michael P. DeVincentis M. D. 23B. ADDRESS: 116 E. Chase St. 23C. DATE SIGNED: 9/14/53

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation 24B. DATE: Sept 16, 1953 24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: Leonard J. Ruck ADDRESS: Leonard J. Ruck, 5305 Harford Road.

MARYLAND STATE DEPARTMENT OF HEALTH 9556

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 45

1. PLACE OF DEATH: COUNTY Balto. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Essex | LENGTH OF STAY (In this place) Balto 24
HOSPITAL OR INSTITUTION OR STREET ADDRESS 408 Northbine ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 408 Woodbine Ave
STREET ADDRESS (If rural, give location) 408 Woodbine Ave - Essex Md

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) L. (Last) Roby.
4. DATE OF DEATH: (Month) Sept (Day) 30 (Year) 53

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Mar. 8. 1891 | 62 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supervisor | Shipyard | Virginia | |

13. FATHER'S NAME Leonard B. Roby
14. MOTHER'S MAIDEN NAME Mary Shelton

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|---|
| No | | | Robt. Roby 120 Fisher Rd |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Coronary occlusion. — Instants

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____ (c) ____

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Sept 9-30-53 12 m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W M Carmine M.D. Deputy Medical Examiner Balto. Co. Towson 2 Md 9/30/53

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 3. 1953 | Oak Lawn | Colgate Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/6/53 | Enid Hurley | Ullrich Funeral Home | 2112 Eastern |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY BALTO. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SPARROWS PT. LENGTH OF STAY (in this place) 30 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1337 FORREST ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY BALTO
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SPARROWS PT. (19) X
STREET ADDRESS (If rural, give location) 1337 FORREST Rd.

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) FREDERICK (Last) RUBY
4. DATE OF DEATH: (Month) 9 (Day) 6 (Year) 19 53

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | OCT. 27, 1875 | 77 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TINNER
10b. KIND OF BUSINESS OR INDUSTRY: STEEL MFG CO
11. BIRTHPLACE (State or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: LLOYD RUBY
14. MOTHER'S MAIDEN NAME: MARGARET McGEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO NO
16. SOCIAL SECURITY NO.: 213-07-6790
17. INFORMANT AND ADDRESS: CHAS. E. RUBY - SAME

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) Cardiac Failure — Interval Between Onset and Death: 9 mos.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Arterio-sclerotic cardiac vascular dis.
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-1-52, 19..., to 9-6, 19.53 that I last saw the deceased alive on 9-6, 19 53, and that death occurred at 7:40 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Robert E. Farber M.D. Sparrows Point Md 9-6-53

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | DATE THEREOF: 9-9-53 | NAME OF CEMETERY OR CREMATORY: PARKWOOD CEM. | LOCATION (City, town, or county) (State): BALTO. Md.

DATE REC'D BY LOCAL REG.: Sept. 7-53 | REGISTRAR'S SIGNATURE: Dawson L. Farber | 24. FUNERAL DIRECTOR ADDRESS: Wells Funeral Home, Dundalk, Md.

RECEIVED
SEP 10 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Baltimore; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort Howard; LENGTH OF STAY (in this place) 146 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural give location) 631 Mosher Street

3. NAME OF DECEASED: (First) LAWRENCE (Middle) B. (Last) SAMPSON

4. DATE OF DEATH: (Month) September (Day) 4 (Year) 19 53

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | 8-4-91 | 62 yrs. | | | | |

| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Waiter | Retired | Baltimore, Maryland | U. S. A. |

13. FATHER'S NAME: Barney Sampson

14. MOTHER'S MAIDEN NAME: Elizabeth Barnett

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| Yes | WW I | 220-03-1133 | Clin.Rec., Vet.Adm.Hosp., Ft.Howard, Md. |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause (163X) | (a) CEREBRAL THROMBOSIS WITH HEMIPLEGIA, LEFT | 27 days |
| DUE TO | | |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) CARCINOMA OF RIGHT LUNG | Unknown |
| DUE TO | | |
| | (c) | |

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 5-12-53 | Pneumonectomy right | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from April 11, 19 53, to Sept. 4, 19 53, [redacted] and that death occurred at 1:45 A.M., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| JOSEPH M. MILLER, M. D., Chief, Surgical Service, VAH | Fort Howard, Md. | 9-4-53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/8/53 | Baltimore National | Baltimore, Maryland |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| September 5, 1953 | R.W | Arlington S. Phillips Funeral Home 1808 N. Monroe Street, Baltimore 17, Md. |

VS-A16

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible] 31

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Landsdowne
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS 204 Second Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Landsdowne
STREET ADDRESS (If rural give location) 204 Second Ave.

3. NAME OF DECEASED: (Type or Print) (First) ROBERT (Middle) E. (Last) SCHAEFFLER

4. DATE OF DEATH: (Month) SEPT: (Day) 1 : (Year) 53 19 ....

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH: MAY: 31:1916

9. AGE last birthday: 37 --- yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Coppers Co.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE SCHAEFFLER

14. MOTHER'S MAIDEN NAME: MARY V. FAGAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO. (If Yes, give war or dates of service) ******

16. SOCIAL SECURITY NO.: 215-10-0979

17. INFORMANT & ADDRESS: GEORGE SCHAEFFLER***Baltimore Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

430.1

Immediate cause (a) Coronary Thrombosis. — 1 hr.

DUE TO arteriosclerosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Angina Pectoris — 4 mon.

DUE TO coronary arteriosclsrosis

(c) — ?

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1952, to Aug. 22, 1953, that I last saw the deceased alive on Aug. 22, 1953, and that death occurred at 12:40 A. , from the causes and on the date stated above.

SIGNATURE (Degree or title) K. Krukenberg MD ADDRESS 400 N. Hilton St. DATE SIGNED Sept. 3, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DATE THEREOF SEPT: 4: 53 NAME OF CEMETERY OR CREMATORY New Cathederal LOCATION (City, town, or county) (State) Baltimore Maryland

DATE REC'D BY LOCAL REGISTRAR 9-3-53 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR F. B. Wippert & Son ADDRESS F.B.WIPPERT & SON 1300 Eutaw Pl.17

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 00532

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY [illegible] MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible] RURAL
LENGTH OF STAY (in this place) 2 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible]

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE [illegible] COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) [illegible]

3. NAME OF DECEASED: (Type or Print) (First) [illegible] (Middle) [illegible] (Last) [illegible]
4. DATE OF DEATH: (Month) 9 (Day) 18 (Year) 1953
5. SEX: [illegible]
6. COLOR OR RACE: [illegible]
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) [illegible]
8. DATE OF BIRTH: [illegible]
9. AGE last birthday: [illegible] yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: [illegible]
10b. KIND OF BUSINESS OR INDUSTRY: [illegible]
11. BIRTHPLACE (State or foreign country): [illegible]
12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: [illegible]

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) [illegible] (If Yes, give war or dates of service) [illegible]
16. SOCIAL SECURITY No.: [illegible]
17. INFORMANT & ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Vascular Accident — Interval Between Onset And Death: 1hr.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardio-Vascular Disease 10 yrs.
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: [illegible]
19b. MAJOR FINDINGS OF OPERATION [illegible]
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) [illegible]
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) [illegible] (CITY OR TOWN) [illegible] (COUNTY) [illegible] (STATE) [illegible]

TIME OF INJURY (Month) (Day) (Year) (Hour) m. [illegible]
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? [illegible]

22. I hereby certify that I attended the deceased from May, 1949, to Sept., 1953, that I last saw the deceased alive on Sept. 18, 1953, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) C. M. Kammer, Jr. ADDRESS 501 Sheridan Ave. DATE SIGNED 9/19/53

23. BURIAL, CREMATION, REMOVAL (Specify) [illegible] DATE THEREOF [illegible] NAME OF CEMETERY OR CREMATORY [illegible] LOCATION (City, town, or county) [illegible] (State) [illegible]

DATE REC'D BY LOCAL REGISTRAR 9-21-53
REGISTRAR'S SIGNATURE A. W. Hedrich dmr.
24. FUNERAL DIRECTOR [illegible] ADDRESS [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0[illegible]3

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**

COUNTY Baltimore — MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Catonsville

LENGTH OF STAY (in this place) 24½ yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE Maryland COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City

STREET ADDRESS (If rural, give location) Not known

**3. NAME OF DECEASED: (Type or Print)** (First) Robert (Middle) Cameron (Last) SCHEIDT

**4. DATE OF DEATH:** (Month) Sept. (Day) 23, (Year) 1953

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** married

**8. DATE OF BIRTH:** Sept. 27, 1888

**9. AGE last birthday:** 64 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Watchmaker

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?** U.S.

**13. FATHER'S NAME:** Dr Robert F Scheidt

**14. MOTHER'S MAIDEN NAME:**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY No.:** none

**17. INFORMANT & ADDRESS:** Records- Spring Grove State Hospital

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Acute Myelogenous Leukemia — Interval Between Onset and Death: 1 year

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☑ No ☐

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 14, 1953, to Sept. 22, 1953, that I last saw the deceased alive on Sept. 22, 1953, and that death occurred at 1:15 A.m., from the causes and on the date stated above.

SIGNATURE Ethel B Heymann-Grandma (DEGREE OR TITLE) ADDRESS 9/23/53 DATE SIGNED

**23. BURIAL, CREMATION, REMOVAL (Specify):** DATE THEREOF Sept 26-1953 — NAME OF CEMETERY OR CREMATORY Parkwood — LOCATION (City, town, or county) (State) Baltimore

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

**24. FUNERAL DIRECTOR** Wm Cook Inc — ADDRESS 1217 St Paul St

VS-A15 Rev. 1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3

# CERTIFICATE OF DEATH

Reg. Dist. No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parkville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2620 Wycliffe Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parkville
STREET ADDRESS (If rural give location) 2620 Wycliffe Road

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Creston (Last) Schemm

4. DATE OF DEATH: (Month) Sept. (Day) 17 (Year) 19 53

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Aug. 4, 1906

9. AGE Last birthday: 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Sheet Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY: Bendix Corp

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Schemm

14. MOTHER'S MAIDEN NAME: Elmira Webb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) W.W.2

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Frances Reisinger Schemm, wife, above

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163.X

Immediate cause (a) Metastatic generalized Carcinoma — Interval Between Onset And Death: 4 mo.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Bronchogenic carcinoma lung. — 6 mo.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 10, 19 53, to Sept 17, 19 53, that I last saw the deceased alive on Sept 17, 19 53, and that death occurred at 4:10 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) John L Byrne M.D. ADDRESS 56 W Hartford Rd DATE SIGNED Sept 18 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Sept. 21, 1953

NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.

LOCATION (City, town, or County) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR SEP 18 REC'D

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.

ADDRESS 2601-3-5 E. Madison St.

VS-A1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 37

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY BALTIMORE — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 52 CATONSVILLE
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 736 BRAESIDE ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND — COUNTY BAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 52 CATONSVILLE
STREET ADDRESS (If rural give location) 736 BRAESIDE ROAD

3. NAME OF DECEASED: (Type or Print) (First) ANNA (Middle) C. (Last) SCRIVENER

4. DATE OF DEATH: (Month) (Day) (Year) SEPT: 22: 1953 19

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED

8. DATE OF BIRTH: 10- 3 -1874

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CONRAD RIPPLE

14. MOTHER'S MAIDEN NAME: CATHERINE TOEPHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) ********

16. SOCIAL SECURITY No.: NONE

17. INFORMANT & ADDRESS: CHARLES R. SCRIVENER JR. ... SAME

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X

Immediate cause (a) Cardio-Vas. Renal Disease — Interval Between Onset And Death: 2 yrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: C

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 51 Sept. 22, 1953, that I last saw the deceased alive Sept. 21, 1953, and that death occurred at 5:30 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) A.P. Von Schweinitz — ADDRESS 4818 Edmondson Ave — DATE SIGNED 9/23/1953

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL — DATE THEREOF SEPT: 24 — NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY — LOCATION (City, town, or county) WOODLAWN (State) Md.

DATE REC'D BY LOCAL REGISTRAR 9-24-53 — REGISTRAR'S SIGNATURE A.W.Hedrich dmr.

24. FUNERAL DIRECTOR F.B. Wippert & Son — ADDRESS F.B. WIPPERT & SON 1300 EUTAW PL.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 68536

# CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Halethorpe. 51
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5546 Selma Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Halethorpe. 51
STREET ADDRESS (If rural give location) 5546 Selma Ave.

3. NAME OF DECEASED: (First) Max (Middle) J. (Last) Seibert

4. DATE OF DEATH: (Month) Sept. (Day) 22 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Oct. 27, 1883

9. AGE last birthday: 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Labor.

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Railroad.

11. BIRTHPLACE (State or foreign country): Austria, Hungary

12. CITIZEN OF WHAT COUNTRY? Hungary

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 705-09-0180

17. INFORMANT & ADDRESS: Susie M. Seibert. 5546 Selma Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause | (a) Hypertensive Cardio Vascular disease DUE TO | several yrs. |
| Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last. | (b) Congestive failure DUE TO | 1 yr. |
| | (c) | |

443X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: C — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. ..., 1951, to Sept 22, 1953, that I last saw the deceased alive on Sept. 22, 1953, and that death occurred at ..., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Charles Tommasello M.D. — 910 W. Lombard St. — Sept 23/53.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept. 26, 1953 — NAME OF CEMETERY OR CREMATORY: Louden Park — LOCATION (City, town, or county) (State): Baltimore Maryland

DATE REC'D BY LOCAL REGISTRAR: 9-23-53 — REGISTRAR'S SIGNATURE: A.W. Hedrich dmr.

24. FUNERAL DIRECTOR — ADDRESS: Joseph T. Embrose 132 S. Dolphin St. Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH: COUNTY Balto MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X
LENGTH OF STAY (in this place) 80 yrs 5 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Shaffer Rd Back River

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X
STREET ADDRESS (If rural give location) Shaffer Rd Back River Neck

3. NAME OF DECEASED (Type or Print): (First) Gilmore (Middle) B. (Last) Shaffer

4. DATE OF DEATH: (Month) Sept (Day) 27 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: Dec 1 1865

9. AGE last birthday: 87 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own. Farm

11. BIRTHPLACE (State or foreign country): Carroll. Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jabez Shaffer

14. MOTHER'S MAIDEN NAME: Sophia Haines

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Miss Viola Shaffer Shaffer Rd. Balto 21

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

177X Immediate cause (a) Carcinoma of Prostate — 2 yrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Erysipelas of face — 1 wk.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1947, to Sept 27, 1953, that I last saw the deceased alive on Sept 27, 1953, and that death occurred at 2:40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James F. White M.D 422 Eastern ave Baltimore 21. Md 9/28/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 9/29/53

NAME OF CEMETERY OR CREMATORY: Hiss Meth Cem

LOCATION (City, town, or county) (State): Balto Md

DATE REC'D BY LOCAL REG. 10/2/53

REGISTRAR'S SIGNATURE: Edith Hurley

24. FUNERAL DIRECTOR ADDRESS: Lansdun Funeral Home T401. Belair Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 6 1953
BUREAU V. S.

3

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson
LENGTH OF STAY (in this place) 5+
HOSPITAL OR INSTITUTION OR STREET ADDRESS 405 Brook Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson
STREET ADDRESS (If rural, give location) 405 Brook Road

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Frank | Byrn | Shepherd | Sept | 15 | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | July 12, 1880 | 73 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman - retired | Building Supplies | Cambridge, Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank Shepherd | |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | | Mrs. Henry A. Gardner — 27 W. Kirke St. Chevy Chase, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

17X Immediate cause (a) Uremic poisoning — 7 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Metastatic Carcinoma

(c) Prostatectomy June 1950

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 3/12, 1953, to Sept 15, 1953, that I last saw the deceased alive on 9/12, 1953 and that death occurred at 11:15 A. m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Jos. A. Sedlack M.D. | 200 W. Pennsylvania Ave., Towson | 9-15-53 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9 - 17 - 53 | Druid Ridge | Pikesville, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | John O. Mitchell & Sons, Inc. M B Mitchell | 1900 Eutaw Place Baltimore, Md. |

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Joseph A. Sedlack

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 44

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Fort Howard
LENGTH OF STAY (in this place): 50 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 1100 E. Lanvale Street

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) F. (Last) SHERALD

4. DATE OF DEATH: (Month) (Day) (Year) September 17 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: 4/25/10

9. AGE last birthday: 43 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Manager

10b. KIND OF BUSINESS OR INDUSTRY: Department store

11. BIRTHPLACE (State or foreign country): Frederick, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Sherald

14. MOTHER'S MAIDEN NAME: Bessie Ely

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): ✓ Yes
(If Yes, give war or dates of service): WW II

16. SOCIAL SECURITY No.: 213-16-1654

17. INFORMANT & ADDRESS: Vet.Adm.Hosp., Ft. Howard, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157X

Immediate cause (a) CARCINOMA OF TAIL OF PANCREAS — Interval Between Onset And Death: 3 months

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) .....

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

VA

22. I hereby certify that I attended the deceased from July 29, 1953, to Sept. 17, 1953, that I last saw the deceased alive on [illegible] and that death occurred at 1:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): WILLIAM S. VANDEGRIFT, M.D. — ADDRESS: VAH, FORT HOWARD, MD. — DATE SIGNED: 9/18/53

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: 9-21-1953 — NAME OF CEMETERY OR CREMATORY: Mt. Olivet — LOCATION (City, town, or county): Frederick, Md. — (State)

DATE RECD BY LOCAL REGISTRAR: Sept. 18 53 — REGISTRAR'S SIGNATURE: Dawson L. Barber

24. FUNERAL DIRECTOR: C. E. KLINE FUNERAL HOME — ADDRESS: E. Patrick Street, Frederick, Md.

VS/A15

RECEIVED
SEP 21
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 1/5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Balto. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fullerton
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 211 Henry Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MD COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fullerton X
STREET ADDRESS (If rural give location) 211 Henry Ave.

3. NAME OF DECEASED (Type or Print) (First) Nicolaus (Middle) Fred. (Last) Sippel

4. DATE OF DEATH (Month) Sept (Day) 14th (Year) 1953

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH July 19th 1885

9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Louis Sippel

14. MOTHER'S MAIDEN NAME Gertrude Marx.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs N. F. Sippel - 211 Henry Ave. Balto 6. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X Immediate cause (a) Carcinoma of Lung. — Interval Between Onset and Death: 3 months.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 28, 1953, to Sept. 14, 1953, that I last saw the deceased alive on Sept. 14, 1953, and that death occurred at 9:30 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James R. Wilson. M.D. 5019 Philadelphia Road Sept. 14, 1953

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF 9/17/53 — NAME OF CEMETERY OR CREMATORY Parkwood Cem. — LOCATION (City, town, or county) Balto. City (State) MD

DATE REC'D BY LOCAL REG. Sept 16 1953 — REGISTRAR'S SIGNATURE Irma M. K. Bilyeu

24. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home - 7401 Belair Rd. Balto 6. MD.

RECEIVED
SEP 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Baltimore — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 53 Dundalk
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. — COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dundalk 22,
STREET ADDRESS (If rural, give location) 2905 Dunmurry Rd.

3. NAME OF DECEASED (Type or Print) (First) Mrs (Middle) Bell J. (Last) Smith
4. DATE OF DEATH (Month) Sept (Day) 12 (Year) 1953

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | Aug 19, 1894 | 59 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Shoe Store | Georgia | |

13. FATHER'S NAME Albert Jones
14. MOTHER'S MAIDEN NAME Avie Stringer

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | | Emmel Smith 2905 Dunmurry Road |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Failure — 2 wks.

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Feb, 1953, to Sept. 1953 that I last saw the deceased alive on 12 Sept, 1953 and that death occurred at 7:35 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J H Morrison MD 3 Kinship Rd Balto. 22 13 Sept 53

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 14/53 | Pleasant Hope | Rome Ga |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9/14/53 | A. N. Hedrick M.D. | Ulrich Funeral Home | 2112 Dundalk Ave. |

Former Address 1611 E. 30th St

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Balto MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Towsonville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sheppard Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towsonville
STREET ADDRESS (If rural, give location) 6811 Campfield Rd

3. NAME OF DECEASED (Type or Print): (First) Charlotte (Middle) Dorothea (Last) Smith

4. DATE OF DEATH: (Month) Sept (Day) 23 (Year) 1953

5. SEX F | 6. COLOR OR RACE W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widow | 8. DATE OF BIRTH June 3 1875 | 9. AGE Last birthday 78 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Balto Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John H. Schmidt | 14. MOTHER'S MAIDEN NAME Hahn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS Records Sheppard 6811 Campfield Rd

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42 Immediate cause (a) Arterio - Sclerotic Heart — Interval Between Onset and Death: 2 yrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) with - Chronic Pulmonary

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cataract Both Eyes

19a. DATE OF OPERATION None | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1951, to Sept. 23, 1953, that I last saw the deceased alive on Sept. 17, 1953, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Earl L. Chambers M.D. 4108 Mount Hy Baltimore 9-24-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Sept 26-53 | NAME OF CEMETERY OR CREMATORY Loudon Cem. | LOCATION (City, town, or county) (State) Balto Md

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR Chas F Kellman | ADDRESS 6067 Harf. Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS Form 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chattalonee
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Railroad Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chattalonee
STREET ADDRESS (If rural, give location) Railroad Ave

3. NAME OF DECEASED: (Type or Print) (First) Douglas (Middle) O. (Last) Smith

4. DATE OF DEATH: (Month) Sept. (Day) 24 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Aug. 31, 1892

9. AGE last birthday: 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: William Smith

14. MOTHER'S MAIDEN NAME: Mary Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Alice D. Smith Chattalonee Baltimore Co., M

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

180X

Immediate cause (a) Cachexia — Interval Between Onset and Death: 1 mos

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Carcinomatosis generalized — DUE TO

(c) Cancer of the Kidney — 1 yr.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. —

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from ....., 19.47., to Sept., 19.53., that I last saw the deceased alive on Sept 23, 1953., and that death occurred at 2 a.m., from the causes and on the date stated above.

SIGNATURE Louis Dahman — (DEGREE OR TITLE) M.D. — ADDRESS 1413 Reisterstown Rd Pikesville — DATE SIGNED 9/25/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 9-26-53 — NAME OF CEMETERY OR CREMATORY St. Luke's Cem — LOCATION (City, town, or county) Reisterstown (State) Md.

DATE REC'D BY LOCAL REG 9-25-53 — REGISTRAR'S SIGNATURE A.W.Hedrich dmr.

24. FUNERAL DIRECTOR Thomas A. Hensley & W. Biddle — ADDRESS 818 St

Item 7- Filed 9158 9/22/53 mnt.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:** COUNTY Baltimore 18 MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville; LENGTH OF STAY (in this place) 52; HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital Catonsville

**2. USUAL RESIDENCE (HOME) OF DECEASED:** STATE Md COUNTY Baltimore; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore - Catonsville; STREET ADDRESS (If rural, give location) Salvation Army 925 South Fremont Street

| 3. NAME OF DECEASED: (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| John | | Smith | Sept. | 16 | 1953 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 12/9/1878 | 74 yrs. | | |

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): —

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Md

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Charles Smith

**14. MOTHER'S MAIDEN NAME:** Anne Feragin

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service) None

**16. SOCIAL SECURITY NO.:** ?

**17. INFORMANT & ADDRESS:** Hospital records, Spring Grove State Hospital

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| 430.0 Immediate cause | (a) Heart Failure due to Arteriosel. Heart D. | |
| DUE TO | | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) and Gangrene of left foot | |
| DUE TO | | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| 0 | | |

**21.** ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/13, 1953, to 9/16, 1953, that I last saw the deceased alive on 9/16, 1953, and that death occurred at 8: P.M. m., from the causes and on the date stated above.

| SIGNATURE | (DEGREE OR TITLE) ADDRESS | DATE SIGNED |
|---|---|---|
| Stella Wachsler M.D. | Spring Grove State Hospital | |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 19-53 | Glen Haven | Glen Burnie Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-18-53 | A.W. Hedrich dear. | Stewart Mortuary | Balto Md. |

VS-A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS House of Pines 16 Fusting Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pikesville
STREET ADDRESS (If rural give location) 3200 Marnat Road

3. NAME OF DECEASED (Type or Print): (First) Max (Middle) (Last) Stein
4. DATE OF DEATH: (Month) Sept. (Day) 19 (Year) 1953
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 24, 1898
9. AGE last birthday: 55 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Proprietor
10b. KIND OF BUSINESS OR INDUSTRY: Ladies Shop
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Morris Stein
14. MOTHER'S MAIDEN NAME: Rose Lena Levinson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Robert Levin - 3200 Marnat Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

153X Immediate cause (a) Carcinoma colon

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Metastasis lung

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 2yrs ago
19b. MAJOR FINDINGS OF OPERATION: Carcinoma Colon
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) X
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY X (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1953, to Sept, 1953, that I last saw the deceased alive on Sept 11, 1953 and that death occurred at 7:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Sidney R Gorris M.D. 803 Cathedral St Sept. 20, 1953

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Sept 20, 1953
NAME OF CEMETERY OR CREMATORY: Beth Israel Cemetery
LOCATION (City, town, or county) (State): Bowleys Lane Balto Md.

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR: Sol Levinson & Bros. ADDRESS 1124 W North ave

Victor E Harris mmb

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 22 1933
BUREAU V. S.

Item 18 Film G158 10-5-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

30

Reg. Dist. No. 52

1. PLACE OF DEATH: COUNTY Baltimore; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville; LENGTH OF STAY (In this place) 7 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Baltimore; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville; STREET ADDRESS (If rural, give location) Catonsville, R. F. D.

3. NAME OF DECEASED (Type or Print): (First) Harry; (Middle) C.; (Last) Stevens

4. DATE OF DEATH: (Month) Sept.; (Day) 20; (Year) 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 4-2-83

9. AGE last birthday: 70 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles F. Stevens

14. MOTHER'S MAIDEN NAME: Margaret Childs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Merrill F. Stevens 932 W. University Pkwy. Baltimore

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause (a) Pneumonia

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) due to Decompensated heart disease

(c) due to Arteriosclerotic heart disease

Interval Between Onset and Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. WAS (ACCIDENTAL) CAUSE PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ✓, Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, I did find said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✓, accident , suicide , homicide , undetermined .

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Geo. F. Kieffer M.D. Dept. Med. Univ. Balto. 1010 Leeds Ave. Sept. 20 53

DISPOSITION (Burial, cremation, removal, donation, etc.) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial Sept 22 1953 All Saints Cemetery Sunderland, Md.

DATE RECD BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

Sept. 21, 1953 ~~Grace E. Hutchins~~ Victor E. Harry M.D. Wm H. Hutchins, Owings, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Notch Cliff near Towson
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Villa Maria Glenarm Rd

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Arm Maryland
STREET ADDRESS (If rural, give location) Glen Arm Road.

3. NAME OF DECEASED (Type or Print): (First) Sister Mary (Middle) Fulgentia (Last) Streibig
4. DATE OF DEATH: (Month) SEPT. (Day) 6 (Year) 1953

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | June 1, 1874 | 79 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: RELIGIOUS TEACHER
11. BIRTHPLACE (State or foreign country): Philadelphia, Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aloysius Streibig
14. MOTHER'S MAIDEN NAME: Louise Hattel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT AND ADDRESS: Sr. Mary Clara Notch Cliff M.D.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

44.3X

Immediate cause (a) CARDIAC INSUFFICIENCY — 1.3 yrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
(c) HYPERTENSIVE C.V.D.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: NONE
19b. MAJOR FINDINGS OF OPERATION: NONE
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) NEITHER
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) NONE m.
INJURY OCCURRED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 SEP, 1953, to 6 SEP, 1953, that I last saw the deceased alive on 6 SEP, 1953, and that death occurred at 4.55 P. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| William Rupich | M.D. | 8 E. Eager St Balto 2 Md | 6 Sep 53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY, OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 9-8-53 | Villa Maria Cem. | Notch Cliff near Towson, Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR |
|---|---|---|
| 9-9-1953 | A.W. Hedrich dmr. | Charles S. Zeller 901 S. CONKLING ST. BALTO. 24, MD. |

3 copies

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort Howard
LENGTH OF STAY (in this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Veterans Administration Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 18
00-01-4
STREET ADDRESS (If rural give location): 2004 St. Paul Street

**3. NAME OF DECEASED:** (Type or Print) (First) HOMER (Middle) H. (Last) TETER

**4. DATE OF DEATH:** (Month) (Day) (Year) September 18, 1953

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED,** (Specify): Divorced

**8. DATE OF BIRTH:** 9/20/92

**9. AGE last birthday:** 60 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Machinist

**10b. KIND OF BUSINESS OR INDUSTRY:** Truck Co.

**11. BIRTHPLACE** (State or foreign country): Grottos, Virginia

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** George W.

**14. MOTHER'S MAIDEN NAME:** Anna Jane McCallister

**15 WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) Yes — (If Yes, give war or dates of service) WW I

**16. SOCIAL SECURITY NO.:** 209-07-7970

**17. INFORMANT & ADDRESS:** Clin.Rec.,Vet.Adm.Hosp.,Ft.Howard, Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

581.0

Immediate cause (a) CIRRHOSIS OF LIVER. — Unknown

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying csuse last.

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT SUICIDE HOMICIDE** (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

VA

22. I hereby certify that I attended the deceased from Sep. 16, 1953, to Sept. 18, 1953 and that death occurred at 5:55 A.M., from the causes and on the date stated above.

SIGNATURE: F. G. Dickey — (Degree or title) — ADDRESS — DATE SIGNED

FRANCIS G. DICKEY, M.D. Chief, Medical Service, VAH, Fort Howard, Md. 9/19/53

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE THEREOF: 9-21-53 — NAME OF CEMETERY OR CREMATORY: Baltimore National — LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR: 18 REC'D — REGISTRAR'S SIGNATURE

**24. FUNERAL DIRECTOR** — ADDRESS: Phillip Cvach Funeral Home, Belmont & Monument St., Balto 5, Md.

13 REC'D

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (1954)

# CERTIFICATE OF DEATH

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Owings Mills
LENGTH OF STAY (in this place) 1 mo. 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 13 Rosewood State Tr. School

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oakland
STREET ADDRESS (If rural give location) Star Route

3. NAME OF DECEASED: (Type or Print) (First) Melinda (Middle) Jill (Last) Thayer

4. DATE OF DEATH: (Month) 9-3-53 (Day) (Year) 19

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 6-23-53

9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months 2 Days 12 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): inmate

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Oakland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Philip Thayer

14. MOTHER'S MAIDEN NAME: Ragenia Elizabeth Compton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Institution records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

75 ✓✓

Immediate cause (a) Broncho pneumonia - bilateral — Interval Between Onset And Death: 2 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Hydrocephalus Spina bifida — conginital

DUE TO

(c) meningocele and club feet

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-30 ....,19..53., to .....9-3....., 19 53 , that I last saw the deceased alive on 9-3-53 19....., and that death occurred at 12:30 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Viola B. Johns / Viola B. Johns, M.D. — ADDRESS M.D Rosewood Owings Mills Md — DATE SIGNED 9-3-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Sept 4/53 — NAME OF CEMETERY OR CREMATORY Oakland Cem. — LOCATION (City, town, or county) Garrett Co — (State) Md.

DATE REC'D BY LOCAL REGISTRAR 9-3-53 — REGISTRAR'S SIGNATURE Mary B. Elmer.

24. FUNERAL DIRECTOR Emory Boldon — ADDRESS Oakland Md.

206334404

RECEIVED
SEP 9 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

**1. PLACE OF DEATH:**
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Catonsville
LENGTH OF STAY (in this place): 14 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 6129 Regent Park Road.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Md. COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Catonsville 58
STREET ADDRESS (If rural, give location): 6129 Regent Park Road-28

**3. NAME OF DECEASED: (Type or Print)** (First) JAMES FRANCIS (Middle) THOMAS. (Last)

**4. DATE OF DEATH:** (Month) Sept (Day) 27 (Year) 1953.

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)** Married

**8. DATE OF BIRTH:** Feb 7. 1899

**9. AGE last birthday:** 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Police –

**10b. KIND OF BUSINESS OR INDUSTRY:** Balto City

**11. BIRTHPLACE** (State or foreign country): Westernport Md.

**12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME:** Michael Thomas.

**14. MOTHER'S MAIDEN NAME:** Mary Gill

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) / (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Frances E. Thomas-6129 Regent Park Road.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cancer Lung — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) — DUE TO (c)

163X

INTERVAL BETWEEN ONSET AND DEATH: years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 5., 19 49., to Sept 27 19 53, that I last saw the deceased alive on Sept 27., 19 53, and that death occurred at 10 50 P m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

E. Smedley MD 651 N Bentalou St Balto Md 9/29/53

**23. BURIAL, CREMATION, REMOVAL (Specify):** Burial — DATE THEREOF: Oct 1. 1953 — NAME OF CEMETERY OR CREMATORY: Meadowridge — LOCATION (City, town, or county) (State): Cesups. Md.

DATE REC'D BY LOCAL REG. 9/29/53 — REGISTRAR'S SIGNATURE: a w Hedrick

**24. FUNERAL DIRECTOR** ADDRESS: John H. Teufel 5311 Edmondson Ave

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05851

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort Howard
LENGTH OF STAY (in this place) 20 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: 22, -2
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 111 W. London Avenue

3. NAME OF DECEASED: (First) LAURENCE (Middle) E. (Last) TODD
4. DATE OF DEATH: (Month) September (Day) 24, (Year) 1953

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: 9/18/95
9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laundry work
10b. KIND OF BUSINESS OR INDUSTRY: Laundry
11. BIRTHPLACE (State or foreign country): Toddville, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Edward Todd
14. MOTHER'S MAIDEN NAME: Sussie Pirchett

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO.: 214-10-9498
17. INFORMANT & ADDRESS: Clin.Rec., Vet.Adm.Hosp., Ft.Howard, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) CARCINOMA, SQUAMOUS CELL, LEFT TEMPLE, WITH — UNKNOWN
DUE TO METASTASIS TO BRAIN AND LUNGS.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour)
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 4, 1953, to Sept. 24, 1953, that I last saw the deceased and that death occurred at 9:20 A.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
FRANCIS G. DICKEY, M.D. Chief, Medical Service, VAH, Fort Howard, Md. 9/24/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 27, 1953
NAME OF CEMETERY OR CREMATORY Mardela Cemetery
LOCATION (City, town, or county) (State) Mardela, Maryland
DATE REC'D BY LOCAL REGISTRAR 9-28-53
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR ADDRESS
HOLLOWAY & COMPANY, SALISBURY MARYLAND
Holloway Funeral Home, Church Street Salisbury, Md.

Permit issued 9-24-53 Mary W. Holloway
Holloway & Co

Item #11 #12 - Filed 6158 9/22/53 mnk.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 5 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:** Catonsville
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) 52
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Douglas Home

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md. COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville 52
STREET ADDRESS (If rural, give location) 5921 Old Frederick Road

**3. NAME OF DECEASED:** (Type or Print) (First) David (Middle) M. (Last) Tolliver

**4. DATE OF DEATH:** (Month) Sept. (Day) 11 (Year) 1953

**5. SEX:** M

**6. COLOR OR RACE:** C

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Married

**8. DATE OF BIRTH:** July 11, 1887

**9. AGE** last birthday: 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Janitor

**10b. KIND OF BUSINESS OR INDUSTRY:** Johns Hopkins Hosp.

**11. BIRTHPLACE** (State or foreign country): Altoona, Pa.

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** John Tolliver

**14. MOTHER'S MAIDEN NAME:** Julia Willis

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:** None

**17. INFORMANT & ADDRESS:** Lillian M. Tolliver, 1920 Bentalou St.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.0

Immediate cause (a) Mitral Insufficiency — Interval Between Onset and Death: 9mo-9da

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b) Arterio-sclerotic Heart Disease — ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-7-, 19 52 to 9-12-, 19 53 that I last saw the deceased alive on 9-12-53, 19....., and that death occurred at 8.00 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Eli Maloney M.D. 57 Winterset Lane. Balto. 28 9/12/53

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE THEREOF Sept. 16/1953 — NAME OF CEMETERY OR CREMATORY Mt. Auburn — LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. 9/15/53 — REGISTRAR'S SIGNATURE W W Hedrick

**24. FUNERAL DIRECTOR** Charles R. Law, 802 Madison Ave ADDRESS

VS A15

5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415 8-52

**1. PLACE OF DEATH:**
COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
LENGTH OF STAY (in this place): 2 mons. 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riverdale
STREET ADDRESS (If rural, give location) 4511 Madison Street

| 3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) | 4. DATE OF DEATH: (Month) (Day) (Year) |
|---|---|
| James Parvin Tucker | September 2, 1953 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 6-11-1886 | 67 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk-Specialist | | North Carolina | USA |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| James Tucker | Martha Hoen |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| Unknown | Unknown | Records Spring Grove State Hospital |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause 331X | (a) Cerebral hemorrhage | 2 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — DUE TO | (b) Cerebral arteriosclerosis | Years |
| DUE TO | (c) Generalized arteriosclerosis | Years |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| M. | | |

22. I hereby certify that I attended the deceased from 9-1, 1953, to 9-2, 1953, that I last saw the deceased alive on 9-2, 1953, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

SIGNATURE Ethel B. Hermann, Asst. M.O. (DEGREE OR TITLE) ADDRESS Spring Grove State Hospital, Catonsville 28, Maryland DATE SIGNED 9-3-53

| 23. BURIAL, CREMATION, REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| | 9-4-53 | Forest Hill Cemetery | Suitland | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-2-53 | T. E. Harry | W. W. Chambers Co | 1400 Chapin St |

RECEIVED
SEP 4 1953
BUREAU V. S.

Item 18 Film G158 10-5-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

0855

Reg. Dist. No. 3

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Rosewood State Training School
COUNTY Balto. Owings Mills MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) / LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: Prince Georges
STATE COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland
STREET ADDRESS (If rural give location) 5661 St Barnabas Road

3. NAME OF DECEASED: (Type or Print) (First) Albert (Middle) Allen (Last) Valentine

4. DATE OF DEATH: (Month) 9- (Day) 26 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 6-10-48

9. AGE last birthday: 5 yrs. IF UNDER 1 YEAR: Months 3 Days 16 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Washington DC

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Henry George Valentine

14. MOTHER'S MAIDEN NAME: Lilly Mai Patton Valentine

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Inspiratory Pneumonia — Interval Between Onset And Death: 1 day

353.0

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Spastic Quadriplegia with Athetosis — birth

DUE TO (c) Petit Mal Epilepsy (Inanition) — birth

Microcephaly

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-26-8 a.m., 1953, to 9-26 8 p.m. 1953., that I last saw the deceased alive on 9-26-8 p.m. 1953, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

SIGNATURE Evelyn Wang (Degree or title) M.D. ADDRESS Rosewood Training School. DATE SIGNED 9/26/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Sept. 29 1953 NAME OF CEMETERY OR CREMATORY Arlington National Cem. LOCATION (City, town, or county) Arlington Va. (State)

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR William J Duckett & Sons ADDRESS Rhode Island Ave.

VS. A15

Item 4 - Film B 158 - 9/16/53 mnt

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY BALTO; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DUNDALK; LENGTH OF STAY (in this place) 2 YRS; HOSPITAL OR INSTITUTION OR STREET ADDRESS 8144 DUNDALK AVE; MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY BALTO; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DUNDALK 22; STREET ADDRESS (If rural, give location) 8144 DUNDALK,

3. NAME OF DECEASED (Type or Print): (First) MARGARETTA (Middle) ELIZABETH (Last) VAN SCYOC

4. DATE OF DEATH: (Month) Sept (Day) 11 (Year) 19 53

5. SEX: FEM.

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW

8. DATE OF BIRTH: 14 MARCH, 1868

9. AGE last birthday: 85 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: JAMES A. ARMSTRONG

14. MOTHER'S MAIDEN NAME: MARY E. GRAHAM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: MRS. GRACE WALTER — SAME

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| 42 1 Immediate cause | (a) Coronary Occlusion | 1 hr. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arterio Sclerotic Hypertensive Heart | 2 yrs. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 19 53 to Sept 11, 19 53, that I last saw the deceased alive on Sept 12, 19 53, and that death occurred at 4:10 P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| [signature] | M.D. | 620 Dist. Sp 4-19 | 9-11-53 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 9/15, 1953 | CHURCH HILL | PORT ROYAL, PENNA |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Sept. 11-53 | Dawson L. Harbin | Wolfe Burke Funeral | Newlake, Md |

VS: A15

RECEIVED
1953
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville, | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 315 Ingleside Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY 4
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore,
STREET ADDRESS (If rural, give location) 2700 Maryland Ave.

3. NAME OF DECEASED (Type or Print): (First) Lillian (Middle) Hammond (Last) Voight
4. DATE OF DEATH: (Month) Sept. (Day) 29, (Year) 1953

5. SEX: Female | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH: Dec. 6, 1861 | 9. AGE last birthday: 91 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dr. Robert G. Hall | 14. MOTHER'S MAIDEN NAME: Rebecca Prill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS: Mrs. Bessie McGinn Calverton Apt. 25th. St. Calvert &

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Myocardial failure — Interval between onset and death: 72 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c) Arteriosclerosis, generalized, severe — Unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Basal cell carcinoma, RT Cheek — Unknown

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 10, 1952, to Sept 29, 1953, that I last saw the deceased alive on Sept 29, 1953, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Stephen Le Marquis M.D. | ADDRESS Catonsville 28 Md. | DATE SIGNED 9-30-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Oct. 1, 1953 | NAME OF CEMETERY OR CREMATORY: Mount Olivet | LOCATION (City, town, or county): Baltimore, | (State): Md.

DATE REC'D BY LOCAL REG. 9/30/53 | REGISTRAR'S SIGNATURE A.W. Aldrich M.D. | 24. FUNERAL DIRECTOR: John O. Mitchell & Son Inc | ADDRESS: 1900 Futaw Place

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Baltimore — STATE: MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Catonsville
LENGTH OF STAY (in this place): 2yrs. 3mos. 24days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Spring Grove State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY:
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore X
STREET ADDRESS (If rural give location): 8 W. Overlea Avenue

3. NAME OF DECEASED (Type or Print): (First) John (Middle) (Last) Walden

4. DATE OF DEATH: (Month) September (Day) 30, (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 10-1883

9. AGE last birthday: 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Walden

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unknown (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT & ADDRESS: Records Spring Grove State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
Immediate cause (a) Cardio respiratory failure — Interval Between Onset And Death: 5 min.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Arteriosclerotic heart disease — Years
DUE TO
(c) Generalized arteriosclerosis — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-3-, 1953, to 9-30-, 19 53, that I last saw the deceased alive on 9-29-, 1953, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Ethel B. Hermann-Grow MD
ADDRESS: Spring Grove State Hospital Catonsville 28, Maryland
DATE SIGNED: 9-30-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 10/2/53
NAME OF CEMETERY OR CREMATORY: Mt Carmel Cem
LOCATION (City, town, or county) (State): Balto Md

DATE REC'D BY LOCAL REGISTRAR: 10/3/53
REGISTRAR'S SIGNATURE: V E Harry

24. FUNERAL DIRECTOR: Lansdale Funeral Home
ADDRESS: 7401 Belair Rd

RECEIVED
OCT 5 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Fort Howard
LENGTH OF STAY (in this place): 72 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Veterans Adm. Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural 14X-
STREET ADDRESS (If rural give location): Rock Hall

**3. NAME OF DECEASED:** (Type or Print) (First) ELWOOD (Middle) R. (Last) WARD

**4. DATE OF DEATH:** (Month) September (Day) 19, (Year) 19 53

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 7-13-99 | 54 yrs. | | | | |

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Carpenter
**10b. KIND OF BUSINESS OR INDUSTRY:** Building
**11. BIRTHPLACE** (State or foreign country): Rock Hall, Md.
**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** John Ward
**14. MOTHER'S MAIDEN NAME:** Ella Ashley

**15 WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW II
**16. SOCIAL SECURITY No.:** 213-12-5253
**17. INFORMANT & ADDRESS:** Clin.Rec., Vet.Adm.Hosp. Ft.Howard,Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 X
Immediate cause (a) DIABETES MELLITUS — Interval Between Onset And Death: Unknown
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 9, 1953, to Sept. 19, 1953, that I last saw the deceased alive on [illegible] and that death occurred at 8:15 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title): WILLIAM B. VANDEGRIFT, M.D. — ADDRESS: VAH, Fort Howard, Maryland — DATE SIGNED: 9-21-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9-23-53 — NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cemetery — LOCATION (City, town, or county) (State): Rock Hall, Maryland

DATE REC'D BY LOCAL REGISTRAR: 9-22/53 — REGISTRAR'S SIGNATURE: A.W.Hedrich

24. FUNERAL DIRECTOR — ADDRESS: Howard Blight Funeral Home, Harford Rd. Baltimore, Md.

Mildred T. Blight, 6009 Harford Rd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-52

**1. PLACE OF DEATH:**
COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN Catonsville
LENGTH OF STAY (in this place) 6yrs. 8mos. 1day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville 16-36 2
STREET ADDRESS (If rural, give location) 3800 58th Street

**3. NAME OF DECEASED:** (Type or Print) (First) Charles (Middle) (Last) Warring

**4. DATE OF DEATH:** (Month) (Day) (Year) September 1, 19 53

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 3-8-1880 | 73 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | South Carolina | USA |

**13. FATHER'S NAME:** William R. Warring

**14. MOTHER'S MAIDEN NAME:** Maria Prentiss

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| Unknown | Unknown | Records Spring Grove State Hospital |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| 794X Immediate cause | (a) Malnutrition | |
| DUE TO | | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) Advanced senility | yrs. |
| DUE TO | | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Multiple decubitus — 1 mo.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| M. | | |

22. I hereby certify that I attended the deceased from 8-26, 1953, to 9-1, 1953, that I last saw the deceased alive on 8-31, 1953, and that death occurred at 7:25 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Ethel B. Neumann-Brew MD Spring Grove State Hospital Catonsville 28 Maryland 9-1-53

| 23. BURIAL, CREMATION OR REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 1-53 | Oak Wood | Arlington |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-1-53 | V. E. Harry | Robert A. Humphrey | Bethesda Md |

RECEIVED
FEB 3 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS. A15

1. PLACE OF DEATH:
COUNTY Baltimore — STATE MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town) X Rural - Rockdale
LENGTH OF STAY (In this place) 5 Years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Clifmor Rd

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Friendship
STREET ADDRESS (If rural give location) Friendship, Md.

3. NAME OF DECEASED: (Type or Print) (First) GERTRUDE (Middle) CROSBY (Last) WEBB

4. DATE OF DEATH: (Month) 9 (Day) 5 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: July 30 1896

9. AGE last birthday: 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John [redacted] Crosby

14. MOTHER'S MAIDEN NAME: Alberta Wilkerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-20-6026

17. INFORMANT & ADDRESS: Emmett Webb.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death: 8 hours

Immediate cause (a) Coronary Thrombosis.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Hypertensive Cardio - Vascular Disease. DUE TO

(c) Arteriosclerosis.

420.1

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 19 49, to Sept. 5, 1953, that I last saw the deceased alive on 9/5, 1953, and that death occurred at 4:50 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Elmira E. Pierpont, M.D. — ADDRESS 8204 Liberty Rd Balto 7, Md. — DATE SIGNED 9/5/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Sept 6/53 — NAME OF CEMETERY OR CREMATORY Friendship — LOCATION (City, town, or county) Anne Arundel County (State) Md

DATE REC'D BY LOCAL REGISTRAR 9/5/53 — REGISTRAR'S SIGNATURE Marie Martin

24. FUNERAL DIRECTOR Harry Huetzke — ADDRESS 411 Edmondson Ave Balt 29 Md

RECEIVED
7 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

6886

Reg. Dist. No.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS (A15)

**1. PLACE OF DEATH**
COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sparrows Point
LENGTH OF STAY (In this place): 23 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 306 E. Street

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland
COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sparrows Point X
STREET ADDRESS (If rural, give location): 306 E Street

**3. NAME OF DECEASED (Type or Print)**: (First) Mildred (Middle) Eugena (Last) Westbrook

**4. DATE OF DEATH**: (Month) September (Day) 27 (Year) 1953

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)**: Married

**8. DATE OF BIRTH**: June 27, 1911

**9. AGE last birthday**: 42 yrs. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

**10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)**: At Home

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE (State or foreign country)**: Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U S A

**13. FATHER'S NAME**: Jesse Behler

**14. MOTHER'S MAIDEN NAME**: Elsie Appleby

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)**: NO
(If year, give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT AND ADDRESS**: Leroy F. Westbrook 306 E. St. Sparrows Point

**18. MEDICAL CERTIFICATION**

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

260X

Immediate cause (a) Acute Coronary Insufficiency — Interval Between Onset and Death: 2 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Diabetes Mellitus — 8 yrs.

(c) Uric Arteriosclerosis — 2 yrs

**II. OTHER SIGNIFICANT CONDITIONS**
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE (Specify)**:

**PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)**:

(CITY OR TOWN) (COUNTY) (STATE)

**TIME OF INJURY** (Month) (Day) (Year) (Hour) m.:

**INJURY OCCURRED** While at Work ☐ Not While At work ☐

**HOW DID INJURY OCCUR?**:

**22.** I hereby certify that I attended the deceased from July 1, 1950, to Sept 27, 1953, that I last saw the deceased alive on Sept 27, 1953, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

SIGNATURE: James T. Means (Degree or title): M.D. ADDRESS: 520 Old Sparrows Point Rd DATE SIGNED: 9/27/53

**23. BURIAL, CREMATION, REMOVAL (Specify)**: Burial

**DATE**: Sept. 30, 1953

**NAME OF CEMETERY OR CREMATORY**: Druid Ridge

**LOCATION (City, town, or county) (State)**: Pikesville, Maryland

**DATE REC'D BY LOCAL REG.**: 9/28/53

**REGISTRAR'S SIGNATURE**: C. F. Kirbach M.D.

**24. FUNERAL DIRECTOR**: Burgee Funeral Home ADDRESS: 3631 Falls Road Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 62

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH:
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort Howard
LENGTH OF STAY (in this place): 20 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 36 W. West Street

3. NAME OF DECEASED: (First) LEWIS (Middle) A. (Last) WHEATLEY
4. DATE OF DEATH: (Month) September (Day) 9 (Year) 19 53
5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 9-30-91
9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Jeffery Wheatley
14. MOTHER'S MAIDEN NAME: Alie (MN: Unknown)
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ✓ Yes (If Yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO.: 214-03-7488
17. INFORMANT & ADDRESS: Clin.Rec., Vet.Adm.Hosp., Ft.Howard, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause: 022X
(a) SYPHILITIC- ARTERIOSCLEROTIC CARDIOVASCULAR
DUE TO DISEASE WITH ANEURYSM OF THORACIC AORTA

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 20, 19 53, to Sept. 9, 19 53, [illegible] and that death occurred at 3:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
FRANCIS G. DICKEY, M. D., Chief, Medical Service, VAH, Fort Howard, Maryland 9-9-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9/14/53 — NAME OF CEMETERY OR CREMATORY: Baltimore National — LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR: 9-11-53 — REGISTRAR'S SIGNATURE: A.W.Hedrich

24. FUNERAL DIRECTOR ADDRESS: Isaiah L. Brown & Son Funeral Home, 123 W. Montgomery Street, Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) 52 Catonsville
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove Hosp.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 29-28 Zone 52.
STREET ADDRESS (If rural, give location) 112 Melvin Ave

**3. NAME OF DECEASED:** (Type or Print) (First) SUSIE (Middle) T. (Last) WILHELM.

**4. DATE OF DEATH:** (Month) Sept (Day) 3 (Year) 19 53

**5. SEX:** F

**6. COLOR OR RACE:** W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** WIDOW

**8. DATE OF BIRTH:** JULY 5, 1863

**9. AGE last birthday:** 90 (?) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:** Housework

**11. BIRTHPLACE** (State or foreign country): U.S.A. Virginia

**12. CITIZEN OF WHAT COUNTRY:** USA

**13. FATHER'S NAME:** HENRY? STOCKMAR

**14. MOTHER'S MAIDEN NAME:** MARGARET DIACON

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) — (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** MRS FRANK W. WILHELM Balto Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Generalized Arteriosclerosis

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause: stating underlying cause last (b) Cerebral Hemorrhage.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-24, 19 53, to 7-5, 19 53, that I last saw the deceased alive on 7-3, 19 53, and that death occurred at ... m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Spring Grove State Hospital (Supt.) Catonsville 9/3/53

**23. BURIAL, CREMATION, REMOVAL** (Specify) Burial — DATE THEREOF 9-5-53 — NAME OF CEMETERY OR CREMATORY Lorraine Park — LOCATION (City, town, or county) Woodlawn (State) Md.

DATE REC'D BY LOCAL REG. 9-5-53 — REGISTRAR'S SIGNATURE T. E. Harris

**24. FUNERAL DIRECTOR** George A. Farley — ADDRESS Catonsville Md

RECEIVED
SEP 9 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 38 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Baltimore — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Parkville
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 2314 Miller Avenue

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Parkville
STREET ADDRESS (If rural give location): 2314 Miller Avenue

**3. NAME OF DECEASED:** (Type or Print) (First) (Middle) (Last): Mr. Walter Willhauck

**4. DATE OF DEATH:** (Month) (Day) (Year): September 22 1953

**5. SEX:** male

**6. COLOR OR RACE:** white

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** married

**8. DATE OF BIRTH:** Nov. 29, 1887

**9. AGE last birthday:** 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired): Welsh Const. Company

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Baltimore, Maryland

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Frederick Willhauck

**14. MOTHER'S MAIDEN NAME:** Martha Daughton

**15 WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.): unk. — (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Wife. Mrs. Emma H. Willhauck, 2314 Miller Ave

**18. MEDICAL CERTIFICATION**

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

156.1
Immediate cause (a) Carcinoma, liver — 6 mos
DUE TO

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Biopsy of liver showed carcinoma

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-29, 1953, to 9-22, 1953, that I last saw the deceased alive on 9/21, 1953, and that death occurred at 10:45 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
G. M. Bacon, M.D. 2810 Taylor Ave. 9/22/53

23. BURIAL, CREMATION, REMOVAL, (Specify): Burial — DATE THEREOF: Sept. 25, 1953 — NAME OF CEMETERY OR CREMATORY: Good Will Cemetery — LOCATION (City, town, or county) (State): Fallston, Maryland

DATE REC'D BY LOCAL REGISTRAR: 9/22/53 — REGISTRAR'S SIGNATURE: G. M. Bacon

24. FUNERAL DIRECTOR (Signature) ADDRESS: Leonard J. Ruck, 5305 Harford Road.

Dr. Bacon

Get Permit.

RECEIVED
SEP 24
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

08865

Reg. Dist. No. ....

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort Howard X
LENGTH OF STAY (in this place) 32 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital 50

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE West Virginia COUNTY Y-1152
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lanark
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) AVERIAL (Middle) (WI) (Last) WILLIAMS

4. DATE OF DEATH: (Month) September (Day) 26 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 9/21/23

9. AGE last birthday: 30 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Welder

10b. KIND OF BUSINESS OR INDUSTRY: Prefabricated work

11. BIRTHPLACE (State or foreign country): Hernshaw, West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bryan

14. MOTHER'S MAIDEN NAME: Madge Dawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO.: 235-28-5352

17. INFORMANT & ADDRESS: Clim.Rec., Vet.Adm.Hosp., Ft.Howard, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X

Immediate cause (a) ADENOCARCINOMA, PROBABLY OF CECUM WITH METASTASIS. Interval Between Onset And Death: UNKNOWN

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: X 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 25, 1953, to Sept. 26, 1953, that I last saw deceased alive on [illegible] 19XXX, and that death occurred at 3:50 A.M., from the causes and on the date stated above.

SIGNATURE A. F. [illegible], M.D. (Degree or title) ADDRESS VAH, Fort Howard, Md. DATE SIGNED 9/28/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 9-28-53 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) West Virginia

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS Howard Blight Funeral Home 6009 Harford Rd. Baltimore, Maryland

SHIP TO: CALFEE FUNERAL HOME OAKWOOD AVE BECKLEY, W. VA. Mildred J. Blight

VS. A[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08866

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Balto. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Halethorpe
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4600 Rehbaum Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Halethorpe
STREET ADDRESS (If rural give location) 4600 Rehbaum Ave.

3. NAME OF DECEASED: (Type or Print) (First) LAURA (Middle) I. (Last) WOODEN

4. DATE OF DEATH: (Month) Sept. (Day) 20 (Year) 19 53

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Aug. 31, 1877

9. AGE last birthday: 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Kinsey Myers

14. MOTHER'S MAIDEN NAME: Mary C. Rawlings

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mr. Frank B. Wooden - ~~4600 Rehbaum Ave.,~~ 4600 Halethorpe, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: few hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Hypostasis of Myocardial Chronic years decompensated — years
DUE TO (c)

420.1

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-30 to 9-20-53, that I last saw the deceased alive on 9-18-53, and that death occurred at 1 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Emma H. Sattell M.D. ADDRESS Rustic Rd. Md. DATE SIGNED 9-22-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 9/23/53

NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.

LOCATION (City, town, or county) (State) Pikesville, Md.

DATE REC'D BY LOCAL REGISTRAR 9-22/53

REGISTRAR'S SIGNATURE A. W. Hedrich dmr.

24. FUNERAL DIRECTOR: Wm. J. Pickner & Sons ADDRESS Balto 17, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08867

# CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS Form 1

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Balto. MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Balto. |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lansdowne 51 — LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lansdowne 51 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 110 - 2nd Ave. | STREET ADDRESS (If rural, give location) 110 - 2nd Ave. |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| LEON | MACE | WOOLFORD | Sept. | 30 | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | June 12, 1887 | 66 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Straw Hatter | Men's Hats | Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Oliver Woolford | Annie Richardson |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | | Mrs. Agnes Woolford-110-2nd Ave. Lansdowne |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| Immediate cause (a) Acute Cardiac failure | ? |
| 331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral accident with right side hemiplegia. | 2mos |
| (c) Cardio Vascular disease | unk |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Sept 8, 1953, to Sept 30 1953, that I last saw the deceased alive on Sept 30, 1953, and that death occurred at 11-30 P.M., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Geo. J. McKeffer DMD | 1170 Washington Blvd | Oct 1 53 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/53 | Meadowridge Mem. Pk. | Elkridge, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/1/53 | a w Hamm JT | Wm. J. Fisher & Sons | Balto. 17, Md |